Notice of Final Agency Action

SUBJECT: MassHealth: Payment for Acute Hospital Services effective October 1, 2006

AGENCY: Massachusetts Executive Office of Health and Human Services (EOHHS), Office of Medicaid

Introduction

The following describes and summarizes changes in MassHealth payment for services provided by in-state acute hospitals. A complete description of the rate year 2007 (RY2007) MassHealth acute hospital inpatient and outpatient payment methods and rates are available at www.mass.gov/masshealth/acutehospitalrfa. For further information regarding RY2007 payment methods and rates, you may contact Kiki Feldmar at the Executive Office of Health and Human Services, Office of Acute and Ambulatory Care, One Ashburton Place, 5th Floor, Boston, MA 02108.

Change in Payment Method

1. Acute Hospital Inpatient Services

A. Summary of Rate Year 2007 Methodology for Calculating the Standard Payment Amount Per Discharge (SPAD) and other Inpatient Services Payments

For hospital rate year 2007, MassHealth will reimburse acute hospitals for Inpatient Admissions via a hospital-specific Standard Payment Amount per Discharge (SPAD). This fixed rate represents payment in full for all non-physician inpatient services for the first 20 days of an admission. Each hospital's SPAD is derived from the statewide average hospital cost per admission in 2003, standardized for casemix differences and area wage variation. An efficiency standard is determined by capping hospital costs, weighted by MassHealth discharges, at the 90% level of costs. The statewide average is adjusted for inflation and outliers. Costs EOHHS determines are routine outpatient costs associated with admissions from the emergency department and routine and ancillary outpatient costs resulting from admissions from observation status are included in the calculation of the statewide average hospital cost per admission. For each hospital, this statewide average is then adjusted for inflation, each hospital's wage area index; and each hospital's specific casemix index. The paid claims of each hospital for patients transferred to another acute hospital (the "transfer per diem") are included in the calculation of each hospital-specific casemix index calculation.

Several categories of costs are directly passed through into the hospital's rate (that is, they are excluded from the statewide average and efficiency adjustments). Hospital-specific costs resulting from malpractice insurance, organ acquisition, and direct medical education are treated as such "pass-throughs." Capital payments are paid on a per-discharge basis, and are efficiency-adjusted. Costs are based on the FY03 DHCFP 403 Cost Report, updated for the hospital's casemix index and inflation to the current year.

The calculation of the pass-through and capital payment amounts includes a determination of the MassHealth average length of stay (ALOS). The ALOS is based on data obtained by the Massachusetts Division of Health Care Finance and Policy (DHCFP) and includes all MassHealth inpatient days, including outlier days.

In addition to the SPAD, EOHHS pays on a per diem basis under certain circumstances. Psychiatric services delivered in DMH-licensed psychiatric beds of acute hospitals are paid an all-inclusive statewide psychiatric per diem rate. Services delivered to individuals who transfer among hospitals or among certain settings within a hospital, as well as inpatient outlier days, are paid adjusted per diem rates.

B. Summary of Changes in Methodology Related to the Calculation of the SPAD and other Inpatient Services

The acute inpatient hospital payment method incorporates the following changes from the RY2006 payment method:

1. It applies an operating inflation update of 1.637% and a capital inflation update of 0.8%.

2. It raises the efficiency standard from 75% to 90%

3. It increases the Outlier Per Diem from 60% to 85% of the Transfer Per Diem.

4. It removes the Primary Care incentive and Specialty Care disincentive from the Direct Medical Education Pass through cost calculation and includes benefits as well as salaries in the costs

5. It includes an update of the Psychiatric Per Diem base year costs from 1992 to 2004 and changes the methodology to a statewide rate.

2. Outpatient Services

A. Summary of Rate Year 2007 Methodology for Calculating the Payment Amount Per Episode (PAPE) and Other Acute Outpatient Hospital Service Payments

The Payment Amount Per Episode (PAPE) methodology establishes a hospital-specific episodic rate for most MassHealth acute outpatient hospital services. The hospital-specific PAPE is based on an outpatient standard payment adjusted for hospital-specific casemix. Certain services, including laboratory services are carved out of the PAPE calculation and payment. Laboratory and other carve out services are paid for in accordance with the applicable fee schedules adopted by DHCFP.

Calculation of the outpatient statewide standard is based on MassHealth payments for outpatient services in Hospital Rate Year 2005, as adjusted by (1) including outlier payments, (2) excluding payments for laboratory services, and (3) bundling only services received on the same day. The result of this calculation is adjusted for inflation to obtain

the outpatient statewide standard factor for Hospital Rate Year 2007. The hospital-specific PAPE is determined by multiplying the outpatient statewide standard by each hospital's casemix index calculated by EOHHS.

B. Summary of Changes

The acute outpatient hospital payment method incorporates the following changes from the Hospital Rate Year 2006 payment method:

1. It applies an inflation update of 1.637%.

2. It provides an update of the APG weights from 1996 to 2004.

3. Adjustments Applied to Hospital Rate Year 2007 Inpatient and Outpatient Rates

The inpatient SPAD and per diem rates, and the outpatient PAPE rates for each hospital will be as specified in the above methodologies for RY2007 or the rate that was in effect for Hospital Rate Year 2006, whichever is greater, except in the case of Massachusetts Eye and Ear Infirmary, whose PAPE rate will be the greater of its RY2007 PAPE rate or its RY2005 PAPE rate.

4. Supplemental Hospital Payments

In addition to the payments specified above, EOHHS makes supplemental payments to certain qualifying hospitals. Supplemental payments are made to hospitals that qualify as Public Service Hospitals, Essential MassHealth Hospitals, Freestanding Pediatric Hospitals, Acute Hospitals with High Medicaid Discharges, High Public Payer Hospitals, Pediatric Specialty Hospitals and Hospitals with Pediatric Specialty Units, and beginning in RY2007, safety net hospitals that qualify for payment pursuant to Section 122 of Chapter 58 of the Acts of 2006.

5. Uncompensated Care Pool Payments to Acute Hospitals

A. Summary of Rate Year 2007 Methodology for Calculating Uncompensated Care Pool Payments to Acute Hospitals

Each hospital's Pool Fiscal Year (PFY) 2007 payment is based on its low-income patient care costs for the period from May 1, 2005, through April 30, 2006, calculated by multiplying each hospital's reported charges by its most recent cost to charge ratio. EOHHS will apply a trend factor to each hospital's Adjusted Base Period Costs to determine its PFY 2007 projected low-income patient care costs. The trend factor is zero for the two Safety Net disproportionate share hospitals with the highest relative volume of low-income patient care costs. For the fourteen disproportionate share hospitals with the next highest relative volume of low-income patient care costs, the trend factor is 5.96%, except that the trend factor is 17.44% for those disproportionate share hospitals with high average charge growth between the first nine months and the last three months of the base period. For non-

disproportionate share hospitals, the trend factor is 14.18% for community hospitals and zero for teaching hospitals.

For the two Safety Net disproportionate share hospitals with the highest relative volume of low-income patient care costs, $70 million of the $550 million in total Acute Hospital funding and $70 million from other distinct sources was used to offset uncompensated care demand, before distributing the remaining $480 million of uncompensated care pool funding to all hospitals.

For each of the sixteen disproportionate share hospitals, the PFY 2007 Total Payment is the greater of (1) 90% of its total FY2006 payment or (2) 100% of its FY 2007 Projected Low Income Patient Care Costs. For all other hospitals, EOHHS will divide the total revenue available after payments to disproportionate share hospitals and a payment adjustment for freestanding pediatric hospitals by the total allowable low income patient care costs for all other hospitals. EOHHS will apply this ratio to each hospital's PFY 2007 projected low-income patient care costs to calculate its PFY 2007 Payment for Low-Income Patient Care Costs.

B. Summary of Changes

1. Updated the base year for determining low income patient care costs;

2 Adjusted base year costs to reflect projected changes in demand;

3. Updated the trend factors; and

4. Established the FY2007 Total Payment for each of the sixteen disproportionate share hospitals as the greater of (1) 90% of its total FY2006 payment or (2) 100% of its FY 2007 Projected Low Income Patient Care Costs.

Justification

The payment methods for rate year 2007 are substantially similar to those for 2006, except as specified above. Changes made regarding hospital payment rates were made in accordance with state and federal law and are within the range of reasonable payment levels to acute hospitals.

General Information

EOHHS estimates that the changes in inpatient and outpatient rates described herein will increase annual expenditures for acute hospital services by approximately $77.6 million. EOHHS estimates that aggregate annual payments to acute hospitals from the Uncompensated Care Trust Fund will increase by $84 million. In accordance with the requirements of Section 124 of Chapter 58 of the acts of 2006, EOHHS estimates that aggregate annual supplemental payments to acute hospitals will increase by $200 million, in accordance with the requirements of Section 122 of Chapter 58 of the acts of 2006.Accordingly, the total estimated effect of the proposed changes in expenditures is an annual increase of approximately $361.6 million.

Statutory Authority: M.G.L. ch.118G; M.G.L. ch.118E; St. 2006, ch.58; St. 2006, ch.139; 42 USC 1396a; 42 USC 1396b; 42 USC 1315.

Related Regulations: 130 CMR 410, 415, 450; 114.6 CMR 11.00; 42 CFR Part 447.

Detailed Description of Acute Hospital Methods

Excerpts from Rate Year 2007 Acute Hospital Request for Applications and Contract

Section 3. Eligible Applicants

A. In-state Acute Hospitals are eligible to apply for a Contract pursuant to the RY07 Request for Applications (RFA) if they:

1. Operate under a Hospital license issued by the Massachusetts Department of Public Health (DPH);

2. Are Medicare certified and participate in the Medicare program;

3. Have more than 50% of their beds licensed as medical/surgical, intensive care, coronary care, burn, pediatric (Level I or Level II), pediatric intensive care (Level III), maternal (Obstetrics), or neonatal intensive care beds (Level III), as determined by DPH; and

4. Currently utilize more than 50% of their beds exclusively as either medical/surgical, intensive care, coronary care, burn, pediatric (Level I or Level II), pediatric intensive care (Level III), maternal (Obstetrics), or neonatal intensive care beds (Level III), as determined by EOHHS.

In determining whether a Hospital satisfies the utilization requirement set forth in **Section 3.A.4**, EOHHS may evaluate, pursuant to an on-site audit or otherwise, a number of factors including, but not limited to, the average length of patient stay (see **Section 10.B.5** of the RFA) at that Hospital.

B. The Hospital shall apply on behalf of all Inpatient Departments, Outpatient Departments, Emergency Departments and Satellite Clinics.

C. The Hospital is not permitted to apply on behalf of, or claim payment for services provided by, any other related clinics, Provider groups, or other entities, except as otherwise provided in **Sections 5.B.9** and **5.C.**

Section 4. Non-Covered Services and Program Initiatives

A. Non-Covered Services

EOHHS will reimburse MassHealth-participating Hospitals at the rates established in this RFA and accompanying Contract for all covered Inpatient, Outpatient, and Emergency Services provided to MassHealth Members *except* for the following:

1. Behavioral Health Services for Members Enrolled with the BH Contractor

EOHHS's BH Contractor contracts with providers to form a network through which behavioral health services are delivered to MassHealth Members enrolled with the BH Contractor. Hospitals in the BH Contractor's network are paid solely by the BH Contractor for services to Members enrolled with the BH Contractor, pursuant to contracts between the BH Contractor and each contracting Hospital.

Hospitals that are not in the BH Contractor's network (hereinafter "non-network Hospitals") do not qualify for MassHealth reimbursement for Members enrolled with the BH Contractor who receive non-Emergency Behavioral Health Services, except in accordance with a service-specific agreement with the BH Contractor. If the BH Contractor offers to pay a non-network Hospital a rate equivalent to that non-network Hospital's applicable RFA rate for the service provided to all Members enrolled with the BH Contractor, that non-network Hospital is required to accept the BH Contractor's rate offer for all MassHealth Members enrolled with the BH Contractor. This requirement does not preclude the BH Contractor from choosing to pay any non-network Hospital at a rate higher or lower than the non-network Hospital's applicable RFA rates for services provided.

Non-network Hospitals that provide medically necessary behavioral health Emergency Services to Members enrolled with the BH Contractor qualify for reimbursement solely by the BH Contractor. Such reimbursement is available only if the Hospital complies with the BH Contractor's service authorization and billing requirements. If a Member enrolled with the BH Contractor receives inpatient behavioral health Emergency Services and the BH Contractor offers to pay the RFA transfer per diem rate capped at the per discharge amount for all substance-related disorder Emergency admissions, or the RFA psychiatric per diem rate for all psychiatric Emergency admissions, whichever is applicable, the non-network Hospital must accept the BH Contractor's rate offer for all MassHealth Members enrolled with the BH Contractor. If a Member enrolled with the BH Contractor receives outpatient behavioral health Emergency Services and the BH Contractor offers to pay the non-network Hospital's applicable RFA rate for all such services provided to a Member enrolled with the BH Contractor, the non-network Hospital must accept the BH Contractor's rate offer for all MassHealth Members enrolled with the BH Contractor. Nothing in this paragraph prohibits the BH Contractor from choosing to pay any non-network Hospital at a rate higher or lower than the non-network Hospital's applicable RFA rates for services provided.

Hospitals are not entitled to any reimbursement from EOHHS, and may not claim such reimbursement for any services that are BH Contractor-covered services or are otherwise reimbursable by the BH Contractor. Any payment by EOHHS for such services shall constitute an overpayment as defined in 130 CMR 450.235. Under such circumstances, EOHHS may also exercise its authority under 130 CMR 450.238 et seq. to impose sanctions for improper billing.

2. MCO Services

Hospitals providing medical services, including behavioral health services, to MassHealth Members enrolled in MCOs will be reimbursed by the MCO for those services that are covered services provided by the MCO. (See **Sections 5.B.10** and **5.C.15**.)

Hospitals may not bill EOHHS for, and EOHHS will not reimburse Hospitals for, services provided to MassHealth Members enrolled in an MCO where such services are covered by the MCO contract with EOHHS. Furthermore, Hospitals may not "balance bill" EOHHS for any services covered by the MCO contract with EOHHS. MCO reimbursements shall be considered payment in full for any MCO-covered services provided to MassHealth Members enrolled in an MCO.

3. Air Ambulance Services

In order to receive reimbursement for air ambulance services, Hospitals must have a separate contract with EOHHS for such services.

4. Non-Acute Units, or Skilled Nursing, and Other Separately Licensed Units in Acute Hospitals

Unless otherwise specified in this RFA, EOHHS shall not reimburse Acute Hospitals through this RFA and the accompanying contract for services provided to Members in Non-Acute Units and any units which have a separate license, such as a skilled nursing unit, or any unit which is licensed to provide services other than Acute Hospital services as described in **Section 3.A.4**.

B. Program Initiatives

1. Hospital Services Reimbursed through Other Contracts or Regulations

The Commonwealth may institute special program initiatives, other than those in this RFA, which provide, through contract or regulation, alternative reimbursement methodologies for Hospital services or certain Hospital services. In such cases, payment for such services is made pursuant to the contract or regulations governing the special program initiative, and not through this RFA and resulting Contract.

2. Demonstration Projects

It is an EOHHS priority to ensure that MassHealth Members receive quality medical care at sites of service that promote delivery of such medical care in a cost-effective and efficient manner. In furtherance of this objective, and subject to state and federal approval requirements, if any, EOHHS may, through separate contracts or through this RFA, institute demonstration projects with Hospitals to develop innovative approaches to encourage site-appropriate delivery of services. Such demonstration projects will be designed to focus on ensuring that Hospitals provide or facilitate the provision of quality services to MassHealth Members in a manner that is efficient and cost-effective and that may include alternative reimbursement methodologies for Hospital services or certain Hospital services.

3. MassHealth Drug List

To help ensure consistency in medication regimens and services, prescribers should conform to the MassHealth Drug List (see www.mass,gov/druglist) whenever medically appropriate for inpatients, outpatients, and upon discharge.

Section 5. Reimbursement System

A. General Provisions

Acute Hospitals that participate in the MassHealth program under the terms of the Hospital Contract and its accompanying payment methodology shall accept payment at the rates established in this RFA as payment in full for services reimbursable by EOHHS that are rendered to MassHealth Members admitted as inpatients or treated as outpatients on or after October 1, 2006.

Non-acute units and units within Hospitals that operate under separate licenses, such as skilled nursing units, will not be affected by this methodology.

The rate of reimbursement to disproportionate share Hospitals, as defined in M.G.L. c. 118G § 1, is subject to promulgation by the Division of Health Care Finance and Policy (DHCFP) of the rate methodology described below.

In accordance with the General Appropriation Act for state fiscal year 2007, any Hospital whose SPAD, inpatient per diem or PAPE payment rate under the payment methodologies described herein for hospital rate year 2007, would otherwise be less than such rates in effect during hospital rate year 2006, shall be paid at the applicable SPAD, inpatient per diem or PAPE rate of payment in effect during hospital rate year 2006, except where the General Appropriation Act for state fiscal Year 2007 specifies otherwise.

B. Payment for Inpatient Services

1. Overview

Except as otherwise provided in **Sections 5.B.6** through **5.B.13,** payments for Inpatient Services provided to MassHealth Members not enrolled in an MCO will be reimbursed a Hospital-specific Standard Payment Amount per Discharge (SPAD) (see **Section 5.B.2**) which will consist of the sum of (1) a statewide average payment amount per discharge that is adjusted for wage area differences and the Hospital-specific MassHealth casemix; (2) a per-discharge, Hospital-specific payment amount for Hospital-specific expenses for malpractice and organ acquisition costs; (3) a per-discharge Hospital-specific payment amount for direct medical education costs, which includes a Primary Care training incentive and a specialty care reduction; and (4) a per-discharge payment amount for the capital cost allowance, adjusted by a Hospital-specific casemix and by a capital inflation factor. Each of these elements is described in **Sections 5.B.2** through **5.B.5**.

Payment for psychiatric services provided in DMH-Licensed Beds to MassHealth Members who are not served either through a contract between EOHHS and its BH Contractor or an MCO shall be made through an all-inclusive Psychiatric Per Diem. (See **Section 5.B.6.**)

Payment for psychiatric services provided in beds that are not DMH-Licensed Beds shall be made at the Transfer per diem rate, capped at the Hospital's SPAD (see **Section 5.B.6** and **5.B.7**).

Payment for physician services rendered by Hospital-Based Physicians will be made as described in **Section 5.B.9**.

2. Calculation of the Standard Payment Amount Per Discharge (SPAD)

In the development of each Hospital's standard payment amount per discharge (SPAD), EOHHS used the SPAD Base Year costs; and RY03 Merged Casemix/Billing Tapes as accepted by DHCFP as the primary sources of data to develop base operating costs per discharge.

The statewide average payment amount per discharge is based on the actual statewide costs of providing Inpatient Services in the SPAD Base Year cost report. The average payment amount per discharge in each Hospital was derived by dividing total inpatient Hospital costs by total inpatient Hospital discharges, omitting those costs and discharges from Excluded Units. Routine outpatient costs associated with admissions from the Emergency Department and routine and ancillary outpatient costs resulting from admissions from observation status were included. The cost centers which are identified as the supervision component of physician compensation and other direct physician costs were included; professional services were excluded. All other medical and non-medical patient care-related staff expenses were included.

Malpractice costs, organ acquisition costs, capital costs, and direct medical education costs were excluded from the calculation of the statewide average payment amount per discharge.

The average payment amount per discharge for each Hospital was then divided by the Hospital's Massachusetts-specific wage area index and by the Hospital-specific RY03 all-payer casemix index that was determined by using RY03 discharges and using the version 12.0 New York Grouper and New York weights. For the non-exempt Massachusetts Hospitals in the areas designated by the Geographical Classification Review Board of the Centers for Medicare and Medicaid Services (CMS), the average hourly wage of each area was calculated from the CMS Hospital Wage Index Public Use File (RY03 Final, updated as of May 11, 2006). Each area's average hourly wage was then divided by the statewide average hourly wage to determine the area's wage index. For the calculation of the Springfield area index, Baystate Medical Center's wages and hours were included. This step results in the calculation of the standardized costs per discharge for each Hospital.

All Hospitals were then ranked from lowest to highest with respect to their standardized costs per discharge; a cumulative frequency of MassHealth discharges for the Hospitals was produced from the casemix data described above. The efficiency standard was established at the cost per discharge corresponding to the position on the cumulative frequency of discharges that represents 90of the total number of statewide discharges

for October 1, 2004, through September 30, 2005. The RY07 efficiency standard is $5329.95.

The statewide average payment amount per discharge was then determined by multiplying a) the weighted mean of the standardized cost per discharge, as limited by the efficiency standard; by b) the outlier adjustment factor of 95%; and by (c) the Inflation Factors for Operating Costs between RY03 and RY07. The resulting RY07 statewide average payment amount per discharge is $4,022.98.

The statewide average payment amount per discharge was then multiplied by the Hospital's MassHealth casemix index adjusted for outlier acuity (using version 12.0 of the New York Grouper and New York weights) and the Hospital's Massachusetts-specific wage area index to derive the Hospital-specific standard payment amount per discharge (SPAD). To develop the Hospital's RY07 casemix index, EOHHS used casemix discharge data submitted to DHCFP by the Hospital, as accepted into DHCFP's database as of June 30, 2006, for the period October 1, 2004, through September 30, 2005, which was then matched with the MassHealth SPAD and transfer claims for MassHealth discharges during the same period to ensure that only MassHealth claims for discharges were included in the final casemix index calculations. The casemix data did not include discharges from Excluded Units. The wage area indexes were derived from the CMS Hospital Wage Index Public Use File (RY03, updated as of May 11, 2006).

Costs for outpatient ancillary services for Members admitted from observation status are included in Hospital-specific SPADs.

An outlier adjustment is used for the payment of Outlier Days as described in **Section 5.B.8.**

When groupers are changed and modernized, it is necessary to adjust the base payment rate so that overall payment levels are not affected solely by the grouper change. This aspect of "budget neutrality" is an approach that EOHHS is following, and one that has been a feature of the Medicare Diagnosis-Related Group (DRG) program since its inception. EOHHS reserves the right to update to a new grouper.

3. Calculation of the Pass-Through Amounts per Discharge

The inpatient portion of malpractice insurance and organ acquisition costs was derived from each Hospital's RY05 DHCFP 403 cost report as screened and updated by DHCFP as of June 23, 2006. This portion of the Pass-Through amount per discharge is the sum of the Hospital's per-discharge costs of malpractice and organ acquisition costs. In each case, the amount is calculated by dividing the Hospital's inpatient portion of expenses by the number of total, all-payer days for the SPAD Base Year and then multiplying the cost per diem by the Hospital-specific MassHealth Average Length of Stay.

This portion of the RY07 Pass-Through amount per discharge is the product of the per diem costs of inpatient malpractice and organ acquisition costs and the Hospital-specific MassHealth Average Length of Stay, omitting such costs related to services in Excluded Units. The days used in the denominator are also net of days associated with such units.

The inpatient portion of direct medical education costs was derived from each Hospital's RY05 DHCFP 403 cost report submitted to DHCFP, as screened and updated as of June 23, 2006. This portion of the Pass-Through amount was calculated by dividing the Hospital's inpatient portion of direct medical education expenses by the number of total inpatient days and then multiplying the cost per diem by the Hospital-specific MassHealth Average Length of Stay.

4. Capital Payment Amount per Discharge

The capital payment per discharge is a standard, prospective payment for all Hospitals, except for those Hospitals with unique circumstances, as set forth in **Sections 5.D.1** through **5.D.3**, that meet the criteria set forth in the final paragraph of this section. The capital payment is a casemix-adjusted capital cost limit, based on the SPAD Base Year costs updated by the Inflation Factors for Capital Costs between RY03 and RY07.

For each Hospital, the total inpatient capital costs include building and fixed equipment depreciation, major moveable equipment depreciation, major moveable equipment, and long- and short-term interest. Total capital costs are allocated to Inpatient Services through the square-footage-based allocation formula of the DHCFP 403 cost report. Capital costs for Excluded Units were omitted to derive net inpatient capital costs. The capital cost per discharge was calculated by dividing total net inpatient capital costs by the Hospital's total SPAD Base Year days, net of Excluded Unit days, and then multiplying by the Hospital-specific MassHealth Average Length of Stay.

The casemix-adjusted capital cost standard was determined by (a) dividing this cost per discharge by the SPAD Base Year MassHealth casemix index; (b) sorting these adjusted costs in ascending order; and (c) producing a cumulative frequency of discharges. The casemix-adjusted efficiency standard was established at the capital cost per discharge corresponding to the position on the cumulative frequency of discharges that represents 90% of the total number of discharges.

Each Hospital's capital cost per discharge was then held to the lower of its capital cost per discharge or the casemix-adjusted efficiency standard, to arrive at a capped capital cost per discharge. Each Hospital's capped capital cost per discharge is then multiplied by the Hospital's number of MassHealth discharges. The product of the capped capital cost per discharge and the number of MassHealth discharges for each Hospital was then summed and divided by the total number of MassHealth discharges statewide, to arrive at a statewide weighted average capital cost per discharge.
The statewide weighted average capital cost per discharge was then updated by the Inflation Factors for Capital Costs between RY03 and RY07. The statewide weighted average capital cost per discharge for RY07 is $402.88.

The Hospital-specific capital payment per discharge was determined by multiplying the statewide weighted average capital cost per discharge by the Hospital's RY07 casemix index as determined in **Section 5.B.2** above.

5. Maternity and Newborn Rates

Maternity cases in which delivery occurs will be paid on a SPAD basis with one SPAD paid for the mother and one SPAD paid for the newborn. Payment for *all* services (except physician services) provided in connection with such a maternity stay is included in the SPAD amount.

6. Payments for Psychiatric Services

Services provided to MassHealth Members in DMH-Licensed Beds who are not enrolled with the BH Contractor or an MCO shall be paid through an all-inclusive psychiatric per diem, as described below. This payment mechanism does not apply to cases in which psychiatric services are provided to Members enrolled with the BH Contractor or an MCO, except as set forth in **Sections 4.A.1** and **4.A.2**.

Psychiatric Per Diem

Statewide Standard Psychiatric Per Diem Calculation

The Statewide Standard Psychiatric Per Diem Rate is derived using the sum of the following: the Acute Hospital Psychiatric Standard for Overhead Costs, the Acute Hospital Psychiatric Standard for Direct Routine Costs, the Acute Hospital Psychiatric Standard for Direct Ancillary Costs, the Acute Hospital Psychiatric Standard for Capital Costs, plus the Adjustment to Base Year Costs.

A. Data Sources: The base year for inpatient costs is the hospital fiscal year (HFY) 2004. MassHealth utilizes the costs, statistics, and revenue reported in the HFY 2004 DHCFP-403 cost reports.

B. Determination of Base Year Operating Standards.

1. The Standard for Inpatient Psychiatric Overhead Costs is the median of the Inpatient Psychiatric Overhead Costs Per Day for the array of acute hospitals providing mental health services in DMH-licensed beds. The median is determined based upon inpatient psychiatric days.

2. The Standard for Inpatient Psychiatric Direct Routine Costs is the median of the Inpatient Psychiatric Direct Routine Costs Per Day (minus direct routine physician costs) for the array of acute hospitals providing mental health services in DMH-licensed beds. The median is determined based upon inpatient psychiatric days.

3. The Standard for Inpatient Psychiatric Direct Ancillary Costs is the median of the Inpatient Psychiatric Direct Ancillary Costs Per Day for the array of acute hospitals providing mental health services in DMH-licensed beds. The median is determined based upon inpatient psychiatric days.

C. Determination of Base Year Capital Standard

1. Each hospital's base year capital costs consist of the hospital's actual Base Year patient care capital requirement for historical depreciation for building and fixed equipment, reasonable interest expenses, amortization, leases, and rental of facilities. Any gains from the sale of property will be offset against the hospital's capital expenses.

2. Each hospital's base year Psychiatric Capital Cost Per Day equals the base year psychiatric capital cost divided by the greater of**:** the actual base year psychiatric days or eighty-five percent (85%) of the base year maximum licensed psychiatric bed capacity, measured in days.

3. The Standard for Inpatient Psychiatric Capital Costs is the median of the Inpatient Psychiatric Capital Costs Per Day for the array of acute hospitals providing mental health services in DMH-licensed beds. The median is determined based upon inpatient psychiatric days.

D. Adjustment to Base Year Costs: The Standards for Overhead Costs, Direct Routine Costs, and Direct Ancillary Costs are updated using a composite index, which is a blend of CMS's Hospital Prospective Market Basket and the Massachusetts Consumer Price Index. The CMS Capital Input Price Index adjusts the base year capital cost to determine the capital amount. The year-to-year update factors used in the rate calculation are the annual inflation rates for operating costs and capital costs.

Payment for psychiatric services provided in beds that are not DMH-Licensed Beds shall be made at the Transfer per diem rate, capped at the Hospital's SPAD. See **Sections 5.B.7.b(4)** and **5.B.7.b(5)** for payment rules involving transfers to and from DMH-Licensed Beds and BH managed care status.

7. Transfer Per Diem Payments

a. Transfer Between Hospitals

In general, payments for patients transferred from one Acute Hospital to another will be made on a transfer per diem basis, capped at the Hospital-specific SPAD for the Hospital that is transferring the patient.

In general, the Hospital that is receiving the patient will be paid on a per-discharge basis in accordance with the standard methodology specified in **Sections 5.B.2** through **5.B.5**, if the patient is actually discharged from that

Hospital. This includes when a patient is transferred back and is subsequently discharged from the original Hospital. If the patient is transferred to another Hospital, then the transferring Hospital will be paid at the Hospital-specific transfer per diem rate, capped at the Hospital-specific per-discharge amount. Additionally, "back-transferring" Hospitals (Hospitals to which a patient is first admitted and then transferred back after having been transferred to another Acute Hospital) will be eligible for outlier payments as specified in **Section 5.B.8**.

Except as otherwise provided in the following paragraph, the RY07 payment per day for Transfer Patients shall equal the statewide average payment amount per discharge adjusted by the hospital-specific casemix and wage index divided by the SPAD Base Year average all-payer length of stay of 4.48 days, to which is added the Hospital-specific capital, direct medical education, and Pass-Through per diem payments which are derived by dividing the per-discharge amount for each of these components by the Hospital-specific MassHealth Average Length of Stay.

For Hospitals with unique circumstances reimbursed in accordance with the methodology specified in **Sections 5.D.1** through **5.D.3**, the RY07 payment amount per day for Transfer Patients shall equal the individual Hospital's standard inpatient payment amount per discharge adjusted by the hospital-specific casemix and wage index divided by the RY03 average all-payer length of stay of 4.48 days, to which is added the Hospital-specific capital, direct medical education, and Pass-Through per diem payments which are derived by dividing the per-discharge amount for each of these components by the Hospital-specific MassHealth Average Length of Stay.

b. Transfers within a Hospital

In general, a transfer within a Hospital is not considered a discharge. Consequently, in most cases a transfer between units within a Hospital will be reimbursed on a transfer per diem basis capped at the Hospital-specific SPAD. This section outlines reimbursement under some specific transfer circumstances.

Hospitals receiving a transfer per diem may be eligible for outlier payments specified in **Section 5.B.8**, subject to all of the conditions set forth therein.

(1) Transfer to/from a Non-Acute, Skilled Nursing, or other Separately Licensed Unit within the Same Hospital

If a patient is transferred from an acute bed to a Non-Acute, Skilled Nursing, or other separately licensed unit in the same Hospital, the transfer is considered a discharge. EOHHS will pay the Hospital-specific SPAD for the portion of the stay before the patient is discharged to any such unit.

(2) MassHealth Payments for Newly Eligible Members, Members Who Change Enrollment in the PCC Plan, Fee for Service or MCO during a Hospital Stay; or in the Event of Exhaustion of Other Insurance

When a patient becomes MassHealth-eligible, enrolls in or disenrolls from an MCO during the course of a Hospital stay, or exhausts other insurance benefits after the date of admission and prior to the date of discharge, the MassHealth-covered portion of the acute stay will be paid at the transfer per diem rate, up to the Hospital-specific SPAD, or, if the patient is at the Administrative Day level of care, at the AD per diem rate, in accordance with **Section 5.B.11**. When a patient enrolls in or disenrolls from an MCO during the Hospital stay, the non-MCO days will be paid at the transfer per diem rate up to the SPAD.

(3) Admissions Following Outpatient Surgery or Procedure

If a patient who requires Inpatient Hospital Services is admitted following an outpatient surgery or procedure, the Hospital shall be paid at the transfer per diem rate up to the Hospital–specific SPAD.

(4) Transfer between a DMH-Licensed Bed and Any Other Bed within the Same Hospital

Reimbursement for a transfer between a DMH-Licensed Bed and any other bed within a Hospital will vary depending on the circumstances involved, such as managed care status, BH network or non-network Hospital, or the type of service provided. See also **Section 5.B.7.b(5).**

When a Member who is not enrolled with the BH Contractor transfers between a DMH-Licensed Bed and a non-DMH-Licensed Bed in the same Hospital during a single admission, EOHHS will pay the Hospital at the transfer per diem capped at the Hospital-specific SPAD for the non-DMH-Licensed Bed portion of the stay, and at the psychiatric per diem for the DMH-Licensed Bed portion of the stay. (See **Section 5.B.6.)**

If the Member is enrolled with the BH Contractor, EOHHS will pay for the non-DMH-Licensed Bed portion of the stay, and only if it is for medical (i.e., non-psychiatric/substance-related disorder) treatment. In that case, such payment will be at the transfer per diem rate capped at the Hospital-specific SPAD.

(5) Change of BH Managed Care Status during a Behavioral Health Hospitalization

(a) Payments to Hospitals without Network Provider Agreements with EOHHS's BH Contractor

When a Member is enrolled with the BH Contractor during a non-emergency or emergency behavioral health admission at a non-network Hospital, the portion of the Hospital stay during which the Member is enrolled with the BH Contractor shall be paid by the BH Contractor provided that the Hospital complies with the BH Contractor's service authorization and billing policies and procedures.

If the BH Contractor offers to pay the Hospital at the RFA transfer per diem rate, capped at the Hospital-specific SPAD for substance-related disorder services, and at the Psychiatric Per Diem rate for psychiatric services, capped at the Hospital-specific SPAD, the Hospital must accept the BH Contractor's rate offer for all such Members. This requirement does not prohibit the BH Contractor from choosing to pay at a rate higher or lower for all such services provided.

The portion of the Hospital stay during which the Member was not enrolled with the BH Contractor will be paid by EOHHS at the psychiatric per diem rate for psychiatric services in a DMH-Licensed Bed or at the transfer per diem rate, capped at the Hospital-specific SPAD, for substance-related disorder services and for psychiatric services in a non-DMH-Licensed Bed.

(b) Payments to Hospitals that are in the BH Contractor's Provider Network

When a Member is enrolled with the BH Contractor during an emergency or non-emergency behavioral health Hospital admission, the portion of the Hospital stay during which the Member was enrolled with the BH Contractor shall be paid by the BH Contractor at the rates agreed upon by the Hospital and the BH Contractor provided that the Hospital complies with the BH Contractor's service authorization and billing policies and procedures.

The portion of the Hospital stay during which the Member was not enrolled with the BH Contractor will be paid by EOHHS at the Psychiatric Per Diem rate for psychiatric services in a DMH-Licensed Bed; or at the transfer per diem rate, capped at the Hospital-specific SPAD, for substance-related disorder services and for psychiatric services in a non-DMH-Licensed Bed.

8. Outlier Payments

A Hospital qualifies for an outlier per diem payment equal to 85% of the Hospital's transfer per diem in addition to the Hospital-specific standard payment amount per discharge or transfer per diem payment if ***all*** of the following conditions are met:

a. The Medicaid non-managed care length of stay for the hospitalization exceeds 20 cumulative *acute* days at that Hospital (not including days in a DMH-Licensed Bed or days paid by a third party);

b. The Hospital continues to fulfill its discharge planning duties as required in EOHHS's regulations;

c. The patient continues to need acute level care and is therefore ***not*** on Administrative Day status on any day for which an outlier payment is claimed;

d. The patient is not a patient in a DMH-Licensed Bed on any day for which an outlier payment is claimed; and

e. The patient is not a patient in an Excluded Unit within an Acute Hospital.

9. Physician Payment

For physician services provided by Hospital-Based Physicians or Hospital-Based Entities to MassHealth patients, the Hospital will be reimbursed for the professional component of physician services in accordance with, and subject to, the Physician regulations at 130 CMR 433.000 et seq. Such reimbursement shall be at the lower of (1) the fee established in the most current promulgation of the DHCFP regulations at 114.3 CMR 16.00, 17.00, 18.00 and 20.00 (including the applicable facility fee for all services where such facility fee has been established); (2) the Hospital's Usual and Customary Charge; or (3) 100% of the Hospital's actual charge submitted.

Hospitals will be reimbursed for such physician services only if the Hospital-Based Physician or a physician providing services on behalf of a Hospital-Based Entity took an active patient care role, as opposed to a supervisory role, in providing the Inpatient Service(s) on the billed date(s) of service. Physician services provided by residents and interns are reimbursed through the direct medical education (DME) portion of the SPAD payment and, as such, are not reimbursable separately. The Hospital-Based Physician may not bill for any professional component of the service that is billed by the hospital.

Hospitals shall not be reimbursed for inpatient physician services provided by Community-Based Physicians or Entities.

Physician fee schedules are available at the State House Bookstore and at http://www.state.ma.us/DHCFP.

10. Payment Rates for Inpatient Hospital Services Provided to MassHealth Members Enrolled in Managed Care Organizations (MCOs)

If an MCO offers to pay a Hospital a rate equivalent to that Hospital's applicable inpatient RFA transfer per diem for each day of the stay up to the Hospital-specific SPAD and psychiatric per diem rates for all Inpatient Services to all of the MCO's

MassHealth enrollees, that Hospital is required to accept the MCO's inpatient rate offer as payment in full for all the MCO's MassHealth enrollees who are inpatients at that Hospital. See **Section 5.C.15** for the similar requirement for Outpatient Services.

This requirement does not prohibit an MCO from choosing to pay any Hospital at inpatient rates higher or lower than the Hospital's applicable inpatient RFA transfer per diem for each day of the stay up to the Hospital-specific SPAD and psychiatric per diem rates for Inpatient services to the MCO's MassHealth enrollees.

11. Payments for Administrative Days

Payments for Administrative Days will be made on a per diem basis as described below. These per diem rates are all-inclusive and represent payment in full for all Administrative Days in all Acute Care Hospitals.

The AD rate is a base per diem payment and an ancillary add-on.

The base per diem payment is $178.47, which represents the median September 2005 nursing home rate for all nursing home rate categories, as determined by DHCFP.

The ancillary add-on is based on the ratio of ancillary charges to routine charges, calculated separately for Medicaid/Medicare Part B-eligible patients and Medicaid-only eligible patients on AD status, using MassHealth paid claims for the period October 1, 1997 to September 30, 1998.

These ratios are 0.278 and 0.382, respectively. The resulting AD rates (base and ancillary) were then updated by the Inflation Factors for Administrative Days. The resulting AD rates for RY07 are $232.31 for Medicaid/Medicare Part B-eligible patients and $251.22 for Medicaid-only eligible patients.

MassHealth rules and regulations do not allow a patient to be admitted at an AD status, except in limited circumstances outlined in EOHHS regulations. In most cases, therefore, Administrative Days will follow an acute stay in the Hospital.

A Hospital may receive outlier payments for patients who return to acute status from AD status after 20 cumulative MassHealth non-managed care acute days in a single hospitalization. That is, if a patient returns to acute status after being on AD status, the Hospital must add the acute days preceding the AD status to the acute days following the AD status to determine the day on which the Hospital is eligible for outlier payments. The Hospital may not bill for more than one SPAD if the patient fluctuates between acute status and AD status; the Hospital may only bill for one SPAD (covering 20 cumulative MassHealth non-managed care acute days), and then for Outlier Days, as described above.

12. Infant and Pediatric Outlier Payment Adjustments

a. Infant Outlier Payment Adjustment

In accordance with 42 U.S.C. § 1396a(s), EOHHS will make an annual infant outlier payment adjustment to Acute Hospitals for Inpatient Services furnished to infants under one year of age involving exceptionally high costs or exceptionally long lengths of stay. Hospitals will be reimbursed by EOHHS pursuant to the DHCFP regulations at 114.1 CMR 36.00.

b. Pediatric Outlier Payment Adjustment

In accordance with 42 U.S.C. §1396a(s), EOHHS will make an annual pediatric outlier payment adjustment to Acute Hospitals for Inpatient Services furnished to children more than one year of age and less than six years of age involving exceptionally high costs or exceptionally long lengths of stay if provided by a Hospital which qualifies as a disproportionate share Hospital under Section 1923(a) of the Social Security Act. (See **Section 5.E.2** for qualifying Hospitals.) Hospitals will be reimbursed by EOHHS pursuant to the DHCFP regulations at 114.1 CMR 36.00.

13. Rehabilitation Unit Services in Acute Hospitals

A per diem rate for rehabilitation services provided at an Acute Hospital shall apply only to Acute Hospital rehabilitation units operating at Public Service Hospitals in order to meet any remaining service needs following closure of a public rehabilitation hospital.

The per diem rate for such rehabilitation services will equal the average MassHealth RY02 rehabilitation hospital rate, weighted by volume of days, after removing the two lowest-rate rehabilitation hospitals from the average, then updated by inflation factors for operating costs between RY02 and RY07. Acute Hospital Administrative Day rates will be paid for all days that a patient remains in the rehabilitation unit while not at acute or rehabilitation hospital level of care, in accordance with **Section 5.B.11.**

Such units shall be subject to EOHHS's screening program for chronic and rehabilitation hospitals as detailed in 130 CMR 435.408 and requirements detailed in 130 CMR 435.410-411.

C. Outpatient Hospital Services

Note: *Rates for all Outpatient Hospital Services (including Emergency Department services) that are covered under a contract between the Acute Hospital and EOHHS's BH Contractor and that are provided to MassHealth Members enrolled with EOHHS's BH Contractor, shall be governed by terms agreed upon between the Acute Hospital and the BH Contractor as set forth in* ***Section 4.A.1****.*

A Hospital will be reimbursed in accordance with **Section 5.C** for Outpatient Services provided by Hospital Outpatient Departments and Satellite Clinics.

Hospitals will not be reimbursed for Hospital services specified as non-payable in Subchapter 6 of the MassHealth Acute Outpatient Hospital Manual, except as otherwise provided for medically necessary services to a MassHealth Standard Member under 21. Providers should refer to the Early and Periodic Screening, Diagnosis and Treatment regulations at 130 CMR 450.140 et seq., regarding provision of services to MassHealth Standard Members under age 21.

1. Payment Amount Per Episode (PAPE)

Except as otherwise provided for Outpatient Services specified in **Sections 5.C.2** through **5.C.14**, Hospitals will receive a Hospital-specific payment for each Episode, known as the Payment Amount Per Episode (PAPE).

a. PAPE Rate Development

Each Hospital's PAPE is the product of the Outpatient Statewide Standard and the Hospital's Casemix Index, as further described below.

(1) Outpatient Statewide Standard — the PAPE Base Year Outpatient Statewide Standard was set to reflect the mean cost per case calculated using cost data from June 2003 through July 2004 to determine the updated APG case weights for RY07. This mean cost per case amount, $129.32, is equivalent to the cost associated with an APG weight of 1.0. This mean cost per case was multiplied by the Inflation Factor for Operating Costs to determine the PAPE Base Year Outpatient Statewide Standard of $131.28.

The RY07 Outpatient Statewide Standard was then determined by multiplying the PAPE Base Year Outpatient Statewide Standard by the Inflation Factors for Operating Costs between RY05 and RY07. The resulting RY07 Outpatient Statewide Standard is $135.90.

(2) Casemix Index — the Hospital-specific Casemix Index is trended from casemix data from January 1, 2001 through September 30, 2005 to determine the Average APG Weight per Episode for RY07. In every case, the Hospital-specific average APG weight per episode is calculated for the relevant period by dividing the relevant payment by the conversion factor for the relevant period, and then by the number of Episodes. For the PAPE Base Year, the standard APG conversion factor was $119.26.

b. PAPE Provision for Certain Hospitals Subject to Potential Rate Decreases

In accordance with the General Appropriation Act for state fiscal year 2007, any specialty hospital which limits its admissions to patients under active diagnosis

and treatment of the eyes, ears, nose, and throat, whose PAPE payment rate under the payment methodology described in **Section 5.C.1.a.** for hospital rate year 2007, would otherwise be less than the PAPE payment rate in effect during hospital rate year 2005, shall be paid at the PAPE rate of payment in effect during hospital rate year 2005.

c. Payment System

MassHealth processes and pays clean outpatient claims in accordance with 130 CMR 450 et seq.

2. Physician Payments

a. A Hospital may only receive reimbursement for physician services provided by Hospital-Based Physicians or Hospital-Based Entities to MassHealth Members. The Hospital must claim payment for the professional component of physician services in accordance with, and subject to: (1) the Physician regulations at 130 CMR 433.000 et seq.; (2) the Acute Outpatient Hospital regulations at 130 CMR 410.000 et seq.; and (3) other rules regarding physician payment as set forth in this RFA.

b. Such reimbursement shall be the lower of (1) the fee established in the most current promulgation of the DHCFP regulations at 114.3 CMR 16.00, 17.00, 18.00 and 20.00 (including the applicable facility fee for all services where such facility fee has been established); (2) the Hospital's Usual and Customary Charge for physician fees; or (3) the Hospital's actual charge submitted. Hospitals will not be reimbursed separately for professional fees for practitioners other than Hospital-Based Physicians or Hospital-Based Entities as defined in **Section 2** of the RFA.

c. Hospitals will be reimbursed for physician services only if the Hospital-Based Physician or a physician providing services on behalf of a Hospital-Based Entity took an active patient care role, as opposed to a supervisory role, in providing the Outpatient Service(s) on the billed date(s) of service. The Hospital-Based Physician may not bill for any professional component of the service that is billed by the Hospital.

d. Physician Services provided by residents and interns are not separately reimbursable.

e. Hospitals will not be reimbursed for physician services if those services are (1) provided by a Community-Based Physician or Community-Based Entity; or (2) as further described in **Section 5.C**.

f. In order to qualify for reimbursement for physician services provided during the provision of Observation Services, the reasons for the Observation Services, the start and stop time of the Observation Services, and the name of the physician

ordering the Observation Services, must be documented in the Member's medical record.

Physician fee schedules are available at the State House Bookstore and at http://www.state.ma.us/DHCFP.

3. Outpatient Hospital Services Payment Limitations

a. Payment Limitations on Outpatient Hospital Services Preceding an Admission

Hospitals will not be separately reimbursed for Outpatient Hospital Services when an Inpatient Admission to the same Hospital, on the same date of service, occurs following the provision of Outpatient Hospital Services. See **Section 5.B.7.b(3)**.

b. Payment Limitations on Outpatient Hospital Services to Inpatients

Hospitals will not be reimbursed for Outpatient Services provided to any Member who is concurrently an inpatient of any Hospital. The Hospital is responsible for payment to any other Provider of services delivered to a Member while an inpatient of that Hospital.

c. Notification Requirements

For all PCC Plan Members, Hospitals must notify the Member's PCC, in writing, within 48 hours after providing Emergency Department services or admitting the Member for Inpatient Services. Such notice must include the Member's diagnosis, the treatment provided, discharge instructions, and the reason for Inpatient Admission, if applicable.

4. Emergency Department Services

a. Required Screening

All Members presenting in the Emergency Department or dedicated emergency department as defined in 42 CFR 489.24 must be screened and stabilized in accordance with applicable requirements at 42 U.S.C. 1396dd et seq., M.G.L. c. 118E, section 17A, and all applicable regulations.

b. Payment for Emergency Services

Hospitals will be reimbursed for Emergency Services provided in the Emergency Department in the same manner as other Outpatient Services.

c. Payment for Non-Emergency Services in the Emergency Department

Except as provided in **Section 5.C.4.d**, below, the Emergency Department facility screening fee is the exclusive reimbursement for Hospitals providing non-Emergency Services in the Emergency Department.

Hospitals will not be reimbursed an Emergency Department facility screening fee when the Hospital bills a PAPE for the patient for the same date of service.

d. Physician Payment

In addition to the Emergency Department facility screening fee described in **Section 5.C.4.c.**, when a Hospital-Based Physician or a Hospital-Based Entity provides physician services in the course of providing non-Emergency Services in the Emergency Department, the Hospital may be reimbursed an additional professional screening fee in accordance with **Section 5.C.2.b.** The Hospital-Based Physician may not bill for any professional component of the service that is billed by the Hospital.

5. Laboratory Services

a. Payment for Laboratory Services

Hospitals will be reimbursed for laboratory services according to the Outpatient Hospital regulations at 130 CMR 410.455 through 410.459, subject to all restrictions and limitations described in regulations at 130 CMR 401.000 and 450.000.

The maximum allowable payment for a laboratory service shall be at the lowest of the following:

(1) The amount listed in the most current applicable DHCFP Clinical Laboratory Services fee schedule at 114.3 CMR 20.00 and the Surgery & Anesthesia fee schedule at 114.3 CMR 16.00 (available at the State House Bookstore and at http://www.state.ma.us/DHCFP);

(2) The Hospital's Usual and Customary Charge; or

(3) The amount that would be recognized under 42 U.S.C. §13951(h) for tests performed for a person with Medicare Part B benefits.

b. Physician Services

No additional payment shall be made for any physician service provided in connection with a laboratory service, except for Surgical Pathology Services. The maximum allowable payment is payment in full for the laboratory service.

6. Audiology Dispensing

a. Payment for Audiology Dispensing Services

Hospitals will be reimbursed for the dispensing of hearing aids only by a Hospital-based audiologist according to the Audiologist regulations at 130 CMR 426.00 et seq., and at the lower of the most current of the DHCFP fees as established in 114.3 CMR 23.00, or the Hospital's Usual and Customary Charge.

b. Physician Payment

Hospitals may not bill for Hospital-Based Physician services related to the provision of audiology dispensing services.

7. Vision Care Dispensing

a. Payment for Vision Care Services

Hospitals will be reimbursed for the dispensing of ophthalmic materials only by a Hospital-Based optometrist, ophthalmologist or other practitioner licensed and authorized to write prescriptions for ophthalmic materials and services according to the Vision Care regulations at 130 CMR 402.000 et seq., and at the lower of the most current of the DHCFP fees as established in 114.3 CMR 15.00, or the Hospital's Usual and Customary Charge.

b. Physician Payment

Hospitals may not bill for Hospital-Based Physician services related to the provision of vision care services.

8. Ambulance Services

a. Payment for Ambulance Services

Ambulance services shall be classified as either air or ground ambulance services. Ground ambulance services shall be reimbursed by EOHHS subject to all regulations pursuant to 130 CMR 407.000 et seq., in the Transportation Manual. Payment shall be the lower of the rates established by DHCFP under 114.3 CMR 27.00 et seq., or the Hospital's Usual and Customary Charge.

If the costs of ground ambulance services were included by the Hospital in the RY03 DHCFP 403 cost report for Outpatient Hospital Services, no additional reimbursement for ground service ambulance may be billed.

In order to receive reimbursement for air ambulance services, Hospitals must have separate contracts with EOHHS for such services.

b. Physician Payment

Hospitals may not bill for Hospital-Based Physician services related to the provision of ambulance services.

9. Psychiatric Day Treatment Program

a. Payment for Psychiatric Day Treatment Services

For services to Members who are not enrolled with the BH Contractor, EOHHS will reimburse Acute Hospital psychiatric day treatment programs which are enrolled with MassHealth as such according to the Psychiatric Day Treatment Program regulations set forth at 130 CMR 417.401-440, at the lower of rates promulgated by DHCFP, as established in 114.3 CMR 7.03, or the Hospital's Usual and Customary Charge.

Hospitals may not bill for psychiatric day treatment services in addition to Outpatient mental health services if both were delivered on the same day.

In order to qualify for reimbursement, psychiatric day treatment programs must be certified by MassHealth as described in 130 CMR 417.405.

b. Physician Payment

Hospitals may not bill for Hospital-Based Physician or Hospital-Based Entity physician services related to the provision of psychiatric day treatment program services.

10. Dental Services

a. Payment for Dental Services

All covered dental services will be reimbursed by EOHHS, subject to all applicable regulations at 130 CMR 420.000 et seq. at the lower of the most current rates promulgated by DHCFP as established in 114.3 CMR 14.00 et seq., or the Hospital's Usual and Customary Charge, except when the conditions in 130 CMR 420.429(A) or (D) apply. When these conditions apply, EOHHS will reimburse the Hospital according to **Section 5.C.1.** The Hospital-based Dentist may not bill for any professional component of the service that is billed by the hospital.

b. Physician Payment

Hospitals may not bill for Hospital-Based Physician services related to the provision of dental services, except when the conditions in 130 CMR 420.429(A) or (D) apply. Under those circumstances, in addition to the PAPE payment under **Section 5.C.1**, when a Hospital-Based Physician provides physician services, the

Hospital may be reimbursed for such physician services in accordance with **Section 5.C.2**. The Hospital-Physician may not bill for any professional component of the service that is billed by the hospital.

c. HLHC Dental Enhancement Fee

A Hospital that operates one or more HLHCs may receive a dental enhancement fee for providing MassHealth covered dental services, in accordance with 130 CMR 420 et seq., 130 CMR 405.410, and 114.3 CMR 4.05(1). Payment of the HLHC dental enhancement fee is limited to one visit per member per day. In order to receive the dental enhancement fee, the Hospital must comply with the MassHealth Dental Program's separate requirements for the dental enhancement fee.

11. Adult Day Health

a. Payment for Adult Day Health Services

EOHHS will reimburse Hospitals that obtain a separate Adult Day Health provider number for adult day health services as set forth in the Adult Day Health regulations at 130 CMR 404.401-422, at the lower of the most current promulgation of DHCFP fees as established in 114.3 CMR 10.00 et seq., or the Hospital's Usual and Customary Charge.

b. Physician Payment

In addition to the adult day health service payment, when a Hospital-Based Physician or a Hospital-Based Entity provides physician services during adult day health services, the Hospital may be reimbursed for such physician services in accordance with **Section 5.C.2**.

Adult day health service rates are available at the State House Bookstore and at http://www.state.ma.us/DHCFP.

12. Early Intervention Program

a. Payment for Early Intervention Services

EOHHS will reimburse Hospitals that obtain a separate Early Intervention Services provider number for early intervention services as set forth in the Early Intervention Program regulations at 130 CMR 440.401-422, at the lower of the most current promulgation of DHCFP fees, as established in 114.3 CMR 49.00 et seq., or the Hospital's Usual and Customary Charge.

b. Physician Payment

In addition to the early intervention service payment, when a Hospital-Based Physician or Hospital-Based Entity provides physician services during early intervention services, the Hospital may be reimbursed for such physician services in accordance with **Section 5.C.2**.

Early intervention service rates are available at the State House Bookstore and at http://www.state.ma.us/DHCFP.

13. Home Health

a. Payment for Home Health Services

EOHHS will reimburse Hospitals that obtain a separate Home Health Services provider number for home health services as set forth in the Home Health Agency regulations at 130 CMR 403.401-441, at the lower of the most current promulgation of DHCFP fees as established in 114.3 CMR 3.00 or the Hospital's Usual and Customary Charge.

b. Physician Payment

In addition to the home health service payment, when a Hospital-Based Physician provides physician services during home health services, the Hospital may be reimbursed for such physician services in accordance with **Section 5.C.2**.

Home health rates are available at the State House Bookstore and at http://www.state.ma.us/DHCFP.

14. Adult Foster Care

a. Payment for Adult Foster Care Services

EOHHS will reimburse Hospitals that obtain a separate Adult Foster Care Services provider number for adult foster care services at the lower of: 1) the rates developed by EOHHS, or 2) the Hospital's Usual and Customary Charge.

b. Physician Payment

In addition to the adult foster care service payment, when a Hospital-Based Physician or Hospital-Based Entity provides physician services during adult foster care services, the Hospital may be reimbursed for such physician services, in accordance with **Section 5.C.2**.

Adult foster care guidelines and rates will be provided by EOHHS upon request.

15. Payment Rates for Outpatient Hospital Services Provided to MassHealth Members Enrolled in Managed Care Organizations (MCOs)

If an MCO offers to pay a Hospital a rate equivalent to that Hospital's applicable RFA rates for all Outpatient Services to all the MCO's MassHealth enrollees (including outpatient psychiatric services), that Hospital is required to accept the MCO's outpatient rate offer as payment in full for all the MCO's MassHealth enrollees who are outpatients at that Hospital. This requirement does not prohibit an MCO from choosing to pay any Hospital at outpatient rates higher or lower than the Hospital's applicable outpatient RFA rates for all Outpatient Services to the MCO's MassHealth enrollees.

D. Reimbursement for Unique Circumstances

1. Sole Community Hospital

The standard inpatient payment amount per discharge for a Sole Community Hospital (as defined in **Section 2**) shall be equal to the sum of:

95% of the Hospital's RY03 cost per discharge capped at 200% of the statewide average payment amount per discharge, adjusted for casemix and inflation; and the Hospital-specific RY07 Pass-Through amount per discharge and the capital amount per discharge.

Derivation of per-discharge costs is described in **Section 5.B.2**.

Adjustments were made for casemix and inflation as described in **Section 5.B.**
There will also be outlier payments in accordance with **Section 5.B.8**.

Acute Hospitals that receive payment as Sole Community Hospitals shall be determined by EOHHS and will be identified in "**Hospital-Specific Inpatient Rates Effective 10/01/06,"** below.

2. Specialty Hospitals and Pediatric Specialty Units

a. The standard inpatient payment amount per discharge for Specialty Hospitals and Pediatric Specialty Units (as defined in **Section 2** of the RFA) shall be equal to the sum of:

95% of the Hospital's RY03 cost per discharge capped at 200% of the statewide average payment amount per discharge, adjusted for casemix and inflation; and the Hospital-specific RY07 Pass-Through amount per discharge and the capital amount per discharge.

Derivation of per-discharge costs is described in **Section 5.B**.

Adjustments were made for casemix and inflation as described in **Section 5.B**.

There will also be outlier payments in accordance with **Section 5.B.8**.

b. EOHHS shall pay Pediatric Specialty Hospitals and Pediatric Specialty Units 85% of the Hospital's expenses for Inpatient Services, as determined by EOHHS, as further described below, for children discharged from such Hospitals and Pediatric Specialty Units between October 1, 2006 and September 30, 2007, whose casemix acuity is greater than 5.0. Hospitals shall provide to EOHHS upon request, such information, and in such format, as EOHHS determines is necessary to calculate any payment under this section.

EOHHS will periodically reconcile with Pediatric Specialty Hospitals and Pediatric Specialty Units expenses and payments for such cases as follows:

(1) The casemix weight will be determined using the casemix grouper specified in **Section 5.B.2.**

(2) Cases will be identified from MassHealth paid claims. Identified cases will be matched to the Hospital Discharge Dataset submitted by the eligible Hospitals to DHCFP. The casemix weight will be derived from the DHCFP data.

(3) Payments for identified cases will be determined by EOHHS, and shall include SPAD and outlier per diem amounts attributable to such cases.

(4) Expenses for identified cases will be determined by EOHHS by multiplying a cost-to-charge ratio against charges reported on the claim. The numerator of the cost-to-charge ratio will be the amount reported on schedule 18, line 22, column 2 of the hospital's RY05 DHCFP-403 report. The denominator will be the amount reported on schedule 6, line 22, column 2 of the Hospital's RY05 DHCFP-403 report.

(5) The payment amount due pursuant to **Section 5.D.2.b**, if any, will be the difference between 85% of the Hospital's aggregate expenses for identified cases, and aggregate payments for identified cases, as determined in **Section 5.D.2.b**. If the aggregate payments exceed 85% of the aggregate expenses, the payment will be zero.

Acute Hospitals that receive payment as Specialty Hospitals and those with Pediatric Specialty Units will be identified in "**Hospital-Specific Inpatient Rates Effective 10/01/06,"** below. For Hospitals with Pediatric Specialty Units, the payment calculated under this section shall only apply to services rendered in the Pediatric Specialty Unit.

3. Public Service Hospital Providers

a. Inpatient Reimbursement

Public Service Hospitals shall be reimbursed for Inpatient Services as follows, and in accordance with **Section 5.D.3.c.** below. The standard inpatient payment amount per discharge for Public Service Hospitals (as defined in **Section 2** of the RFA) shall be equal to the sum of:

95% of the Hospital's RY03 cost per discharge capped at 200% of the statewide average payment amount, adjusted for casemix and inflation; and the Hospital-

specific RY07 Pass-Through amount per discharge and the capital amount per discharge.

Derivation of per-discharge costs is described in **Section 5.B**.

Adjustments were made for casemix and inflation as described in **Section 5.B.**

There will also be outlier payments in accordance with **Section 5.B.8**.
Acute Hospitals that receive payment as Public Service Hospitals shall be determined by EOHHS and will be identified in "**Hospital-Specific Inpatient Rates Effective 10/01/06,"** below.

b. Outpatient Reimbursement

Public Service Hospitals shall be reimbursed for Outpatient Services in accordance with **Section 5.C** and **Section 5.D.3.c**.

c. Supplemental Medicaid Rate for Public Service Hospitals

Subject to legislative appropriation or authorization, compliance with all applicable federal statutes, regulations, waiver provisions, and payment limits, and the availability of federal financial participation at the rate of no less than 50%, EOHHS will make a supplemental payment to Public Service Hospitals. The payment amount will be (i) determined by EOHHS using data filed by each qualifying Hospital in financial reports as required by EOHHS, and (ii) specified in an agreement between EOHHS and the qualifying Hospital.

EOHHS reserves the right to make payments to Public Service Hospitals in such amounts and pursuant to such methods and using such funding sources as may be approved by CMS.

Acute Hospitals that receive payment as Public Service Hospitals shall be determined by EOHHS.

4. Essential MassHealth Hospitals

a. Qualification

In order to qualify for payment as an Essential MassHealth Hospital, a Hospital must itself meet, or be within a system of hospitals, any one of which meets at least four of the following criteria, as determined by EOHHS, provided that all hospitals within such system are owned or controlled, directly or indirectly, by a single entity that (i) was created by state legislation prior to 1999; and (ii) is mandated to pursue or further a public mission:

(1) The Hospital is a non-state-owned public Acute Hospital.

(2) The Hospital meets the current MassHealth definition of a non-profit teaching hospital affiliated with a Commonwealth-owned medical school.

(3) The Hospital has at least 7% of its total patient days as Medicaid days.

(4) The Hospital is an acute-care general Hospital located in Massachusetts that provides medical, surgical, Emergency and obstetrical services.

(5) The Hospital enters into a separate contract with EOHHS relating to payment as an Essential MassHealth Hospital.

b. Reimbursement Methodology

Subject to legislative appropriation or authorization, compliance with all applicable federal statutes, regulations, waiver provisions, and payment limits, and the availability of federal financial participation at the rate of no less than 50%, EOHHS will make a supplemental payment to Essential MassHealth Hospitals. The payment amount will be (i) determined by EOHHS using data filed by each qualifying Hospital in financial reports as required by EOHHS, and (ii) specified in an agreement between EOHHS and the qualifying Hospital.

EOHHS reserves the right to make payments to Essential MassHealth Hospitals in such amounts and pursuant to such methods and using such funding sources as may be approved by CMS.

Acute Hospitals that receive payment as Essential MassHealth Hospitals shall be determined by EOHHS.

5. Supplemental Medicaid Rate for Freestanding Pediatric Acute Hospitals

Subject to legislative appropriation or authorization, compliance with all applicable federal statutes, regulations, waiver provisions, and payment limits, and federal financial participation at the rate of no less than 50%, EOHHS will make a supplemental payment equal to $5.79 million, to Freestanding Pediatric Acute Hospitals, to account for high Medicaid volume. Such payment amount is determined by EOHHS based on data filed by each qualifying Hospital in its financial and cost reports, and projected Medicaid volume for the Hospital Rate Year.

EOHHS reserves the right to make payments to Freestanding Pediatric Hospitals in such amounts and pursuant to such methods and using such funding sources as may be approved by CMS.

Acute Hospitals that receive payment as Freestanding Pediatric Acute Hospitals shall be determined by EOHHS.

6. Acute Hospitals with High Medicaid Discharges

Subject to legislative authorization, compliance with all applicable federal statutes, regulations, waiver provisions, and payment limits, and federal financial participation at the rate of no less than 50%, EOHHS will make a supplemental payment to Acute Hospitals with High Medicaid Discharges when compared with other participating MassHealth Hospitals. To be eligible for a payment pursuant to this section, a Hospital must have more than 2.7% of the statewide share of Medicaid discharges, as determined by dividing each Hospital's total Medicaid discharges as reported on the hospital's HCF-403 cost report by the total statewide Medicaid discharges for all Hospitals.

The payment amount is the lower of (1) the variance between the Hospital's inpatient Medicaid payments and costs, or (2) the Hospital's Uncompensated Care Safety Net Care funded payment amount.

EOHHS reserves the right to make payments to Acute Hospitals with High Medicaid Discharges in such amounts and pursuant to such methods and using such funding sources as may be approved by CMS.

Acute Hospitals that receive payment as Acute Hospitals with High Medicaid Discharges shall be determined by EOHHS.

7. Certified Public Expenditures

Subject to compliance with all applicable federal statutes, regulations, waiver provisions, and payment limits, and federal financial participation at the rate of no less than 50%, the State may certify as public expenditures eligible for federal financial participation, allowable Medicaid costs incurred by eligible hospitals, or expenditures made by municipalities, or other public entities, for services provided to MassHealth members at a Hospital.

E. Safety Net Care Acute Hospital Payments

MassHealth will assist Hospitals that carry a financial burden of caring for uninsured and publicly insured persons of the Commonwealth. In accordance with the terms and conditions of the Commonwealth's 1115 waiver governing Safety Net Care, and subject to compliance with all applicable federal requirements, MassHealth will make an additional payment above the rate specified in **Sections 5.B, 5.C,** and **5.D** for RY07 to Hospitals which qualify for such payment under any one or more of the classifications listed below. Only Hospitals that have an executed Contract with EOHHS, pursuant to this RY07 RFA, are eligible for the following Safety Net Care payments. If a Hospital's RFA Contract is terminated, its payment shall be prorated for the portion of RY07 during which it had such Contract with EOHHS. The remaining funds it would have received may be apportioned to remaining eligible Hospitals. The following describes how Hospitals will qualify for each Safety Net Care payment described below, and the methodology for calculating those payments.

When a Hospital applies to participate in MassHealth, its eligibility and the amount of the following Safety Net Care payments shall be determined. As new Hospitals apply to become MassHealth Providers, they may qualify for such payments if they meet the criteria under one or more of the following classifications. Therefore, some Safety Net Care payments may require recalculation pursuant to DHCFP regulations set forth at 114.1 CMR 36.00. Hospitals will be informed if the payment amount will change due to reapportionment among the qualified group and will be told how overpayments or underpayments by EOHHS will be handled at that time.

All Safety Net Care payments are subject to the availability of federal financial participation.

1. High Public Payer Hospitals: 63% Hospitals

The eligibility criteria and payment formula for this classification are specified in DHCFP regulations, promulgated in accordance with M.G.L. c. 118G § 11(a) (see 114.1 CMR 36.00). For purposes of this classification, the term "disproportionate share Hospital" refers to any Acute Hospital that exhibits a payer mix where a minimum of 63% of the Acute Hospital's Gross Patient Service Revenue is attributable to Title XVIII and Title XIX of the Social Security Act, other government payers and free care. (See M.G.L. c. 118G, § 1.) Payments shall be made during the term of the RY07 Hospital Contract. Each High Public Payer Hospital's payment is equal to each hospital's share of all allowable free care costs by High Public Payer Hospitals, multiplied by $11.7 million appropriated for this payment.

2. Public Service Hospital Safety Net Care Payment

Subject to legislative appropriation or authorization, compliance with all applicable federal statutes, regulations, waiver provisions, and payment limits, and the availability of federal financial participation at the rate of no less than 50%, EOHHS will make a Public Service Hospital Safety Net Care payment to Hospitals which meet the following criteria: (1) is a public or a Public Services Hospital; (2) has a volume of free care charges in FY93 that is at least 15% of total charges; and (3) is an essential safety net provider in its service area, as demonstrated by the delivery of services to populations with special needs, including persons with AIDS, trauma victims, high-risk neonates, and indigent patients without access to other providers. The payment amount shall be reasonably related to the services provided to patients eligible for medical assistance under Title XIX, or to low-income patients.

The payment amount will be (i) determined by EOHHS using data filed by each qualifying Hospital in financial reports required by EOHHS, and (ii) specified in an agreement between EOHHS and the qualifying Hospital.

EOHHS reserves the right to make safety net care payments to Public Service Hospitals in such amounts and pursuant to such methods and using such funding sources as may be approved by CMS.

Acute Hospitals that receive safety net care payments as Public Service Hospitals shall be determined by EOHHS.

3. Uncompensated Care Safety Net Care Payment

Hospitals eligible for this payment are those acute facilities that incur costs for services to low-income patients as defined by the DHCFP regulations. The payment amounts for eligible Hospitals are determined and paid by DHCFP in accordance with its regulations at 114.6 CMR 11.00. Eligible Hospitals will receive these payments on a periodic basis during the term of their RY07 Hospital Contract.

4. Safety Net Care Payment for Pediatric Specialty Hospitals and Hospitals with Pediatric Specialty Units

The eligibility criteria and payment formula for this classification are specified by regulations of DHCFP, promulgated in accordance with M.G.L. c. 118G, § 11(a) (see 114.1 CMR 36.00). In order to be eligible for this adjustment, the Hospital must be a Pediatric Specialty Hospital or Hospital with a Pediatric Specialty Unit as defined in **Section 2** of the RFA. The availability of and total amount of funds allocated for payment in accordance with this paragraph are subject to specific legislative appropriation.

Acute Hospitals that receive safety net care payments as Pediatric Specialty Hospitals and Hospitals with Pediatric Specialty Units shall be determined by EOHHS.

5. Certified Public Expenditures

Subject to compliance with all applicable federal statutes, regulations, waiver provisions, and payment limits, and federal financial participation at the rate of no less than 50%, the State may certify as public expenditures eligible for federal financial participation, allowable costs incurred by eligible hospitals, or expenditures made by municipalities or other public entities, for uninsured or unreimbursed services or costs at a Hospital.

6. Section 122 of Chapter 58 Safety Net Health System Payments

EOHHS will make supplemental payments to the two publicly operated or public-service state-defined disproportionate share Hospitals with the highest relative volume of uncompensated care costs in hospital fiscal year 2007. As defined in Section 122 of Chapter 58 of the Acts of 2006, total payments under this section will not exceed $200 million for total unreimbursed free care and Medicaid services, including Medicaid-managed care services, and the operation of the respective safety net health care systems. Boston Medical Center and Cambridge Health Alliance are the only Hospitals eligible for this payment.

F. Federal Financial Participation (FFP)

1. FFP Denials

If any portion of the reimbursement pursuant to this RFA is not approved or is the basis of a disallowance by CMS, EOHHS may recoup, or offset against future payments, any payment made to a Hospital in excess of the approved reimbursement.

2. Exceeding Limits

a. Hospital-Specific Limits

If any payments made pursuant to this RFA exceed any applicable federal Hospital-specific payment limits, including, but not limited to, charge limits, upper payment limits, and limits based on federally approved payment methods, EOHHS may recoup, or offset against future payments, any payment made to a Hospital in excess of the applicable limit.

b. Aggregate Limits

If any payments made pursuant to this RFA exceed applicable federal aggregate payment limits, including, but not limited to upper payment limits provided for in federal law, regulations, and the Commonwealth's 1115 waiver, EOHHS may exercise its discretion to apportion the disallowance among the affected Hospitals and to recoup from, or offset against future payments to such Hospitals, or to otherwise restructure payments in accordance with approved payment methods.

G. Billing

The Contractor shall bill for all non-professional services through an 837I or on the UB92 form and all professional component services for Hospital-Based Physician and Hospital-Based Entity (Inpatient and Outpatient) Services through an 837P or on the MassHealth Claim Form 5 except where otherwise indicated by MassHealth regulations, billing instructions, Provider bulletins, or other written statements of policy, and in compliance with all applicable regulations, billing instructions, Provider bulletins, and other written statements of policy, as they may be amended from time to time.

H. Treatment of Reimbursement for Members in the Hospital on the Effective Date of the Hospital Contract

Except where payments are made on a per diem basis, EOHHS shall reimburse participating Hospitals for services provided to MassHealth Members who are at acute inpatient status prior to October 1, 2006, and who remain at acute inpatient status on or after October 1, 2006, at the Hospital's rates established prior to this RY07 RFA. Reimbursement to participating Hospitals for services provided to MassHealth Members who are admitted on or after October 1, 2006, shall be reimbursed at the RY07 Hospital rates.

I. Future Rate Years

Adjustments may be made each Rate Year to update rates and shall be made in accordance with the Hospital Contract in effect on that date.

J. Compliance with Legal Requirements

The parties agree to comply with, and are subject to, all state and federal statutes, rules, and regulations governing the MassHealth Program, and reimbursement and delivery of Acute Hospital services, including but not limited to Acute Inpatient Hospital regulations at 130 CMR 415.00 et seq., Outpatient Hospital regulations at 130 CMR 410.000 et seq., and Administrative and Billing regulations at 130 CMR 450.00 et seq.; provided, however, that in the event of any conflict between the documents that are part of the Hospital's Contract with EOHHS and any MassHealth regulation now existing or hereinafter adopted, the terms of the Contract shall prevail. All references to statutes and regulations refer to such statutes and regulations as they may be amended from time to time. In addition, the parties must comply with all applicable billing instructions and Provider bulletins, and other written statements of policy issued by EOHHS and its divisions, as they may be amended from time to time.

K. Eligibility Verification

EOHHS will pay the Hospital only for a covered service delivered to a Member who, on the date of service, is (1) eligible under MassHealth to receive that service, and (2) not enrolled with a MassHealth managed care provider (including EOHHS's Behavioral Health contractor) that covers the service. Each day of an inpatient Hospital stay constitutes a discrete "date of service." A Member who meets the foregoing conditions on a given date of service may not meet such conditions on all dates of service comprising a Hospital stay. The Hospital is responsible for determining, through the MassHealth Recipient Eligibility Verification System (REVS), that the Member meets the conditions stated herein on each discrete date of service.

L. Errors in Calculation of Pass-Through Amounts, Capital Costs or Casemix

As set forth below, EOHHS will make corrections to the final Hospital-specific rate retroactive to the effective date of the Contract resulting from this RFA. Such corrections will not affect computation of any statewide average or statewide standard amounts or of any of the efficiency standards applied to inpatient and outpatient costs, or to capital costs.

1. Errors in Calculation of Pass-Through or Capital Costs

a. If a transcription error occurred or if the incorrect line was transcribed in the calculation of the RY07 Pass-Through Costs or capital costs, resulting in an amount not consistent with the methodology, a Hospital may request a correction, which shall be subject to agreement by both parties.

b. To qualify for a correction, Hospitals must submit, within six months of the beginning of the Contract year, copies of the relevant report(s), as referenced in **Sections 5.B.3** and **5.B.4**, highlighting items found to be in error, to:

Kiki Feldmar
Executive Office of Health and Human Services
Office of Acute and Ambulatory Care
One Ashburton Place, 5th Floor
Boston, MA 02108

2. Incorrect Determination of Casemix

a. Beginning in RY07, casemix shall be calculated on claims for discharges as described in **Section 5.B**. In the event of an error in the calculation of casemix made by EOHHS or DHCFP resulting in an amount not consistent with the methodology, a Hospital may request a correction to its RY07 casemix, which shall be at the sole discretion of EOHHS.

b. In the event of a Hospital reporting error where the effect of the error is a decrease in the Hospital's SPAD of 30% or more, EOHHS may, in its sole discretion, consider revised data submitted to DHCFP by the Hospital.

c. To qualify for a correction, Hospitals must contact EOHHS in writing during the first six months of Contract year, to determine the documentation necessary to demonstrate that an error has occurred. Please contact:

Director of MassHealth Hospital Program
Executive Office of Health and Human Services
Office of Acute and Ambulatory Care
One Ashburton Place, 5th Floor
Boston, MA 02108-4603

3. Change in Services Affecting Casemix

In the event that a Hospital opens or closes, during the Contract year, an Inpatient Service that the Hospital believes will have a significant effect on casemix, the Hospital must provide EOHHS with a data analysis of the casemix effect for the current Rate Year and the subsequent Rate Year if it requests a casemix adjustment. EOHHS may, in its sole discretion, consider revised data submitted by the Hospital.

M. Data Sources

If data sources specified by this RFA are not available, or if other factors do not permit precise conformity with the provisions of this RFA, EOHHS shall select such substitute data sources or other methodology(ies) that EOHHS deems appropriate in determining Hospitals' rates.

N. New Hospitals/Hospital Change of Ownership

For any newly participating Hospital, or any Hospital which is party to a merger, sale of assets, or other transaction involving the identity, licensure, ownership or operation of the Hospital during the effective period of this RFA, EOHHS, in its sole discretion, shall determine on a case-by-case basis (1) whether the Hospital qualifies for reimbursement under this RFA; and, if so, (2) the appropriate rates of reimbursement. Such rates of reimbursement shall be determined in accordance with the provisions of this RFA to the extent that EOHHS deems possible. EOHHS's determination shall be based on the totality of the circumstances. In cases where any such rate may, in EOHHS's sole discretion, affect computation of any statewide average or statewide standard payment amount and/or any cost standard, MassHealth provider numbers are not assignable to new entities.

See **Sections II.5.a** and **II.5.d** of **Appendix A** in the RFA, and **Appendix B, Item 9** in the RFA**,** for requirements in the event of Hospital change of ownership.

Section 6. Payment and Reporting Provisions

All payments under this RFA are subject to the following provisions, as well as all other rules and regulations governing service limitations, claims payment, billing and claims processing procedures, utilization control requirements and all other MassHealth conditions of payment.

A. Services Requiring Practitioner Prior Approval

EOHHS will not reimburse a Hospital for services provided when the practitioner is required to, but fails to obtain prior authorization, referrals or other approval for the service. It is the Hospital's responsibility to ensure that a practitioner providing services in the Hospital has obtained the necessary approvals.

B. Hospital Payments in the Event of Third-Party Coverage

1. Except to the extent prohibited by 42 U.S.C. § 1396a(a)(25)(E) or (F), the Hospital must make diligent efforts, as defined under 130 CMR 450.316(A), to identify and obtain Insurance Payments before billing MassHealth.

2. For Inpatient Admissions where the Member has Third-Party Insurance coverage, EOHHS will pay the Hospital the RFA payment amount minus the combined amount of the Insurance Payment and the contractual adjustment, or the Member's Liability (i.e., Coinsurance, Copayment, or Deductible), whichever is less.

3. For Outpatient and Emergency Department Services where the Member has Third-Party Insurance coverage, EOHHS will pay the MassHealth Liability minus the combined amount of the Insurance Payment and the contractual adjustment, or the Member's Liability (i.e., Coinsurance, Copayment, or Deductible), whichever is less.

4. For Outpatient Services, except those specified in **Sections 5.C.2** through **5.C.14,** where MassHealth is the secondary payer after the Medicare program, the PAPE shall be the MassHealth Liability. Implementation of this pricing in the MMIS will be effective on or after October 1, 2006. EOHHS will reconcile all claims affected by this provision and adjust payment accordingly.

C. Notification of Hospital Election to Offer Reduced Medicare Coinsurance Amounts

Acute Hospitals have an option to elect to reduce a Medicare beneficiary's Coinsurance amount under the Medicare outpatient prospective payment system. Such election must be made in writing to the Hospital's fiscal intermediary (FI), specifying the services to which it applies. The first such election must have been made by June 1, 2000, and for future years by December 1 of the year preceding the calendar year for which the election is being made.

Hospitals electing to take such an option must forward a copy of their notification to the FI to:

Executive Office of Health and Human Services
Office of Medicaid
Attn.: Claims Coordination Unit
UMass-CHCF
The Schrafft's Center
529 Main Street, 3rd Floor
Charlestown, MA 02129

D. Sterilization

EOHHS will pay for an inpatient stay for a sterilization or for outpatient sterilization services only when the Hospital meets all requirements regarding Member consent and service delivery as set forth in MassHealth regulations, including 130 CMR 485.409. The performance of a sterilization without meeting all such requirements may result in sanctions against the Hospital in accordance with 130 CMR 450.238 et seq. as well as the applicable provisions of this RFA.

E. Cost Reporting Requirements

All Acute Hospitals are required to submit documents needed for the calculation of MassHealth payment rates to DHCFP and EOHHS in accordance with all applicable instructions and requirements. These documents include, but are not limited to, DHCFP 403 cost reports, DHCFP merged billing and discharge filings, CMS Medicare 2552 cost reports, and DHCFP HLHC cost reports for Hospitals with HLHCs. All Acute Hospitals with HLHCs are required to submit HLHC cost report forms developed by DHCFP when EOHHS requests them and in accordance with any applicable DHCFP regulations. If a Hospital does not submit the information specified above in a timely fashion as specified in 114.1 CMR 42.03(2), such a Hospital may have a 5% reduction applied to its SPAD payment rate beginning 45 days after the required submission date. This reduction shall accrue in a cumulative manner of 5% for each month of non-compliance.

For example, the downward adjustment to the Hospital's SPAD for the first month would equal 5%; if the requested documentation is not received for another month, the downward adjustment to the Hospital's SPAD for the second month shall equal 10%. The adjustment shall not, in any case, exceed 50% of the SPAD. If a Hospital is not in full compliance with the submission of the aforementioned information at such time as the Hospital's rate is subject to change (i.e., at the start of a new Rate Year, or upon commencement of an amendment that affects the SPAD rate), at no time can the new rate exceed the adjusted current rate. If, however, the new SPAD rate is less than the rate currently in effect, then the new rate will become effective and potentially subject to further adjustment.

Hospitals must separately identify in the DHCFP 403 cost report any costs associated with rehabilitation units, in accordance with the instructions of DHCFP.

F. Satellite Clinic Reporting

Hospitals shall report on a quarterly basis services provided to a MassHealth Member at a Satellite Clinic in accordance with MassHealth instructions.

G. Quality Reporting Requirements

See **Section 7** and **Appendix G** of the RFA for information.

H. Accident Reporting

Hospitals shall use reasonable efforts to determine whether a Member's injury is due to an accident or trauma (e.g., automobile accident, accident at work). In the event that a MassHealth Member is treated at a Hospital for injuries resulting from an accident or trauma, the Hospital shall notify EOHHS in writing, at the address below, of the following information:

1. Patient's name, MassHealth number (SSN or RID), address, and date of birth;

2. Date(s) of service (*from-to*);

3. Date of injury;

4. Type of accident (e.g., auto accident, accident at work, slip and fall);

5. Insured's name and address;

6. Insurance company's name;

7. Insured's attorney's name, address and telephone number.

Such written notification shall be sent to the following address:

Office of Medicaid
Accident Trauma Recovery Unit
P.O. Box 15205
Worcester, MA 01615-0203
Phone: (800) 754-1864

I. MassHealth Copayments

For any Hospital service for which a Member copayment is applied pursuant to 130 CMR 450.130, EOHHS shall deduct the copayment amount from the applicable Hospital payment amount specified in this RFA. Hospitals may not refuse services to any Member who is unable to pay the copayment at the time the service is provided, and must otherwise comply with all applicable state and federal requirements regarding copayments.

Hospital-Specific Inpatient Rates Effective 10/01/06

Initial Acute Hospital Inpatient Rates-HRY07-RFA07 Effective -10/1/2006-9/30/2007 Hospital	Rate Code 25 UB92=X1 Standard Payment Amt per Discharge	Rate Code 61 UB92=X5 Standard Transfer Payment Amt	Rate Code 28 UB92=X3 Standard Outlier Payment Amt	Rate Code 90 UB92=Y4 Mental Health Payment Amt	Rate Code 84 UB92=Y1 MassHealth w/Medicare B AD payment Amt	Rate Code 85 UB92=Y2 MassHealth Only AD payment Amt	Rate Code 71 Rehab per diem	Rate Code 27 UB92=X2 Pediatric Payment Amt per Discharge	Rate Code 63 UB92=X7 Pediatric Transfer Payment Amt	Rate Code 29 UB92=X4 Pediatric Outlier Payment Amt
ANNA JAQUES HOSPITAL	$ 4,800.60	$ 1,367.08	$ 878.73	$811.98	$ 232.31	$251.22				
ATHOL HOSPITAL	$ 5,609.03	$ 1,632.95	$ 1,008.45	not applicable	$ 232.31	$251.22				
BAYSTATE MED. CTR.	$ 8,219.45	$ 2,215.93	$ 1,462.28	$811.98	$ 232.31	$251.22				
BERKSHIRE MED. CTR.	$ 6,634.90	$ 1,511.30	$ 1,253.43	$811.98	$ 232.31	$251.22				
BETH ISRAEL-DEACONESS	$ 8,797.49	$ 2,267.11	$ 1,638.91	$821.12	$ 232.31	$251.22				
BETH ISRAEL-DEACONESS, NEEDHAM	$ 9,528.69	$ 2,145.78	$ 1,823.91	not applicable	$ 232.31	$251.22				
BEVERLY HOSPITAL	$ 4,978.61	$ 1,131.48	$ 961.76	$811.98	$ 232.31	$251.22				
BOSTON MEDICAL CTR*	$ 11,843.19	$ 3,045.35	$ 2,197.38	not applicable	$ 232.31	$251.22	$ 682.38			
BRIGHAM & WOMEN'S HOSP	$ 8,980.84	$ 2,157.64	$ 1,652.88	not applicable	$ 232.31	$251.22				
BROCKTON HOSPITAL	$ 4,815.58	$ 1,196.13	$ 919.13	$811.98	$ 232.31	$251.22				
CAMBRIDGE HOSPITAL*	$ 5,725.74	$ 1,667.79	$ 1,126.60	$811.98	$ 232.31	$251.22				
CAPE COD HOSPITAL**	$ 5,033.13	$ 1,297.59	$ 982.65	$811.98	$ 232.31	$251.22				
CARNEY HOSPITAL	$ 8,679.35	$ 2,307.25	$ 1,648.77	$821.12	$ 232.31	$251.22				
CHILDREN'S MEDICAL CTR***				$821.12	$ 232.31	$251.22		$ 16,565.79	$ 4,387.23	$ 2,740.90
CLINTON HOSPITAL	$ 6,147.36	$ 1,694.73	$ 1,072.18	$811.98	$ 232.31	$251.22				
COOLEY-DICKINSON HOSP	$ 4,372.72	$ 1,198.41	$ 845.44	$811.98	$ 232.31	$251.22				
DANA FARBER***	$ 17,433.52	$ 4,769.22	$ 3,228.32	not applicable	$ 232.31	$251.22				
EMERSON HOSPITAL	$ 4,291.35	$ 1,093.83	$ 832.29	$811.98	$ 232.31	$251.22				
FAIRVIEW HOSPITAL	$	$	$	not	$ 232.31	$251.22				

	2,979.78	876.02	590.91	applicable						
FALMOUTH HOSPITAL	$ 4,917.10	$ 1,218.13	$ 964.18	not applicable	$ 232.31	$251.22				
FAULKNER HOSPITAL	$ 8,017.44	$ 2,139.06	$ 1,474.51	$821.12	$ 232.31	$251.22				
FRANKLIN MED CTR	$ 4,141.63	$ 1,138.18	$ 813.95	$811.98	$ 232.31	$251.22				
GOOD SAMARITAN MED CTR	$ 5,154.25	$ 1,349.38	$ 988.54	$811.98	$ 232.31	$251.22				
HALLMARK HEALTH	$ 5,152.88	$ 1,436.26	$ 982.03	$811.98	$ 232.31	$251.22				
HARRINGTON MEM'L HOSP	$ 3,783.46	$ 1,059.17	$ 750.61	$811.98	$ 232.31	$251.22				
HEALTH ALLIANCE	$ 4,739.46	$ 1,150.48	$ 943.40	$811.98	$ 232.31	$251.22				
HENRY HEYWOOD HOSP	$ 3,742.04	928.69	740.08	$811.98	$ 232.31	$251.22				

Initial Acute Hospital Inpatient Rates-HRY07-RFA07 Effective -10/1/2006-9/30/2007	Rate Code 25 UB92=X1	Rate Code 61 UB92=X5	Rate Code 28 UB92=X3	Rate Code 90 UB92=Y4	Rate Code 84 UB92=Y1	Rate Code 85 UB92=Y2	Rate Code 71	Rate Code 27 UB92=X2	Rate Code 63 UB92=X7	Rate Code 29 UB92=X4
Hospital	Standard Payment Amt per Discharge	Standard Transfer Payment Amt	Standard Outlier Payment Amt	Mental Health Payment Amt	MassHealth w/Medicare B AD payment Amt	MassHealth Only AD payment Amt	Rehab per diem	Pediatric Payment Amt per Discharge	Pediatric Transfer Payment Amt	Pediatric Outlier Payment Amt
HOLY FAMILY HOSPITAL	$ 5,007.82	$ 1,410.22	$ 914.79	$811.98	$ 232.31	$251.22				
HOLYOKE HOSPITAL	$ 5,591.43	$ 1,581.97	$ 1,068.83	$811.98	$ 232.31	$251.22				
HUBBARD REGIONAL HOSP	$ 6,848.39	$ 1,958.48	$ 1,254.40	not applicable	$ 232.31	$251.22				
JORDAN HOSPITAL	$ 5,362.31	$ 1,320.10	$ 1,029.17	not applicable	$ 232.31	$251.22				
LAHEY CLINIC	$ 13,221.86	$ 2,896.78	$ 2,462.27	not applicable	$ 232.31	$251.22				
LAWRENCE GENERAL HOSP	$ 5,187.15	$ 1,444.03	$ 925.62	not applicable	$ 232.31	$251.22				
LOWELL GENERAL HOSPITAL	$ 4,289.53	$ 1,076.38	$ 831.13	not applicable	$ 232.31	$251.22				
MARLBOROUGH HOSPITAL	$ 7,478.21	$ 2,097.24	$ 1,286.21	$811.98	$ 232.31	$251.22				
MARTHA'S VINEYARD HOSP**	$ 4,810.64	$ 2,051.41	$ 1,230.85	not applicable	$ 232.31	$251.22				
MARY LANE HOSPITAL	$ 3,869.90	$ 908.26	$ 772.02	not applicable	$ 232.31	$251.22				
MASS. EYE & EAR INFIRMARY***	$ 10,929.69	$ 2,431.24	$ 2,066.56	not applicable	$ 232.31	$251.22				
MERCY HOSPITAL	$ 5,886.91	$ 1,308.94	$ 1,112.60	$811.98	$ 232.31	$251.22				
MERRIMACK VALLEY	$ 6,704.21	$ 1,859.38	$ 1,276.31	$811.98	$ 232.31	$251.22				
METROWEST MED CTR	$ 4,199.09	$ 1,066.74	$ 824.32	$811.98	$ 232.31	$251.22				
MASS. GENL. HOSP.-adult	$ 10,345.29	$ 2,324.40	$ 1,846.84	$821.12	$ 232.31	$251.22		$ 15,298.18	$ 2,927.37	$ 2,488.26
MILFORD REGIONAL	$ 4,735.60	$ 1,318.10	$ 926.61	not applicable	$ 232.31	$251.22				
MILTON HOSPITAL	$ 8,552.72	$ 2,095.07	$ 1,586.72	not applicable	$ 232.31	$251.22				
MORTON HOSPITAL	$ 4,818.28	$ 1,283.06	$ 925.20	$811.98	$ 232.31	$251.22				
MOUNT AUBURN HOSPITAL	$ 5,079.42	$ 1,229.34	$ 996.83	$811.98	$ 232.31	$251.22				

NANTUCKET COTTAGE HOSP**	$ 4,835.92	$ 1,403.03	$ 841.82	not applicable	$ 232.31	$251.22				
NASHOBA VALLEY	$ 7,530.28	$ 1,812.56	$ 1,402.65	not applicable	$ 232.31	$251.22				
NEW ENGLAND MEDICAL CTR	$ 9,166.51	$ 2,192.76	$ 1,686.89	$821.12	$ 232.31	$251.22		$ 22,024.08	$ 4,311.32	$ 3,664.62
NEW ENGLAND BAPTIST HOSP	$ 13,515.48	$ 3,425.49	$ 2,502.74	not applicable	$ 232.31	$251.22				
NEWTON-WELLESLEY HOSP	$ 6,014.08	$ 1,436.07	$ 1,160.91	$811.98	$ 232.31	$251.22				
NOBLE HOSPITAL	$ 7,821.70	$ 1,941.70	$ 1,454.61	$811.98	$ 232.31	$251.22				
NORTH ADAMS HOSPITAL	$ 4,545.10	$ 1,330.04	$ 867.64	$811.98	$ 232.31	$251.22				
NORTH SHORE MED CTR	$ 4,986.12	$ 1,364.16	$ 960.34	$811.98	$ 232.31	$251.22				
NORWOOD HOSPITAL	$ 5,264.27	$ 1,452.73	$ 1,016.96	$811.98	$ 232.31	$251.22				
QUINCY MED CTR	$ 7,456.89	$ 1,756.53	$ 1,400.67	$821.12	$ 232.31	$251.22				

Initial Acute Hospital Inpatient Rates-HRY07-RFA07 Effective -10/1/2006-9/30/2007 Hospital	Rate Code 25 UB92=X1 Standard Payment Amt per Discharge	Rate Code 61 UB92=X5 Standard Transfer Payment Amt	Rate Code 28 UB92=X3 Standard Outlier Payment Amt	Rate Code 90 UB92=Y4 Mental Health Payment Amt	Rate Code 84 UB92=Y1 MassHealth w/Medicare B AD payment Amt	Rate Code 85 UB92=Y2 MassHealth Only AD payment Amt	Rate Code 71 Rehab per diem	Rate Code 27 UB92=X2 Pediatric Payment Amt per Discharge	Rate Code 63 UB92=X7 Pediatric Transfer Payment Amt	Rate Code 29 UB92=X4 Pediatric Outlier Payment Amt
SAINTS MEM MED CTR	$ 5,237.85	$ 1,345.46	$ 996.61	not applicable	$ 232.31	$251.22				
SOUTH SHORE HOSPITAL	$ 4,479.16	$ 1,113.27	$ 869.24	not applicable	$ 232.31	$251.22				
SOUTHCOAST	$ 5,903.62	$ 1,453.49	$ 1,108.02	$811.98	$ 232.31	$251.22				
ST. ANNE'S HOSP	$ 7,138.59	$ 1,814.65	$ 1,329.19	not applicable	$ 232.31	$251.22				
ST. ELIZABETH'S HOSPITAL	$ 9,186.06	$ 2,206.71	$ 1,702.92	$821.12	$ 232.31	$251.22				
ST. VINCENT'S HOSPITAL	$ 7,613.33	$ 1,746.23	$ 1,434.56	$811.98	$ 232.31	$251.22				
STURDY MEMORIAL HOSP	$ 4,362.81	$ 1,215.70	$ 838.95	not applicable	$ 232.31	$251.22				
U. OF MASS. MED. CTR.	$ 8,268.66	$ 2,107.52	$ 1,526.82	$811.98	$ 232.31	$251.22				
WINCHESTER HOSPITAL	$ 4,100.17	$ 1,103.94	$ 796.13	not applicable	$ 232.31	$251.22				
WING MEMORIAL HOSPITAL	$ 6,386.05	$ 1,791.97	$ 1,191.59	$811.98	$ 232.31	$251.22				

* Public Service Hospital Providers

** Sole Community Hospital

*** Specialty Hospitals and Pediatric Specialty Units

Hospital-Specific Outpatient PAPE Rates Effective 10/01/06

PROVIDER NAME	PAPE HRY 2007
ANNA JAQUES HOSPITAL	267.98
ATHOL MEMORIAL HOSPITAL	212.41
BAYSTATE MEDICAL CENTER INC	256.46
BERKSHIRE MEDICAL CENTER	295.88
BETH ISRAEL HOSPITAL	258.32
BOSTON MEDICAL CENTER	242.33
BRIGHAM & WOMEN'S HOSPITAL	261.89
BROCKTON HOSPITAL INC.	230.27
CAMBRIDGE HEALTH ALLIANCE	213.14
CAPE COD HOSPITAL	257.55
CARITAS GOOD SAMARITAN MEDICAL CENTER	244.06
CARITAS NORWOOD HOSPITAL	219.14
CARNEY HOSPITAL	236.94
CHILDREN'S HOSPITAL	532.21
CLINTON HOSPITAL	160.04
COOLEY-DICKINSON HOSPITAL	230.30
DANA-FARBER CANCER INSTITUTE	1514.60
DEACONESS-GLOVER HOSPITAL	250.42
EMERSON HOSPITAL	250.48
FAIRVIEW HOSPITAL	341.67
FALMOUTH HOSPITAL	226.15
FAULKNER HOSPITAL INC	322.70
FRANKLIN MEDICAL CENTER	265.50
HALLMARK HEALTH	196.76
HARRINGTON MEMORIAL HOSPITAL	292.14
HEALTH ALLIANCE HOSPITALS	227.29
HEYWOOD HOSPITAL	206.89
HOLY FAMILY HOSPITAL INC.	225.37
HOLYOKE HOSPITAL INC.	276.04
HUBBARD REGIONAL HOSPITAL	175.76
JORDAN HOSPITAL INC.	264.04
LAHEY CLINIC HOSPITAL INC.	300.48
LAWRENCE GENERAL HOSPITAL	268.24
LOWELL GENERAL HOSPITAL	264.36
MARLBOROUGH HOSPITAL	176.89
MARTHAS VINEYARD HOSPITAL	346.76

PROVIDER NAME	PAPE HRY 2007
MARY LANE HOSPITAL	180.37
MASS EYE & EAR INFIRMARY	537.98
MASS GENERAL HOSPITAL	262.08
MERCY HOSPITAL	203.08
MERRIMACK VALLEY HOSPITAL	302.95
METROWEST MEDICAL CENTER (COLUMBIA)	204.34
MILFORD WHITINSVILLE HOSPITAL	248.65
MILTON MEDICAL CNETER	316.72
MORTON HOSPITAL INC.	203.38
MOUNT AUBURN HOSPITAL	319.87
NANTUCKET COTTAGE HOSPITAL	268.81
NASHOBA VALLEY MEDICAL CENTER	281.45
NEW ENGLAND BAPTIST HOSPITAL	241.67
NEWTON-WELLESLEY HOSPITAL	191.62
NOBLE HOSPITAL	198.19
NORTH ADAMS REGIONAL HOSPITAL	193.77
NORTH SHORE MEDICAL CENTER	275.87
NORTHEAST (BEVERLY HOSPITAL CORP)	222.86
QUINCY MEDICAL CENTER	224.02
SAINT VINCENT HOSPITAL	211.88
SAINTS MEMORIAL MEDICAL CENTER	263.06
SOUTH SHORE HOSPITAL	297.55
SOUTHCOAST HOSPITAL	227.59
ST ANNE'S HOSPITAL	267.53
ST ELIZABETH HOSPITAL	326.49
STURDY MEMORIAL HOSPITAL	206.20
TUFTS NEW ENGLAND MEDICAL CENTER	247.81
UMASS MEMORIAL MEDICAL CENTER	220.76
WINCHESTER HOSPITAL	225.01
WING MEMORIAL HOSPITAL	124.56

Emergency Department Screening Fee

The Emergency Department Screening Fee for dates of service from October 1, 2006 through September 30, 2007 will be: **$63.49.**

Uncompensated Care Pool Payments

Uncompensated Care Pool Payments - PFY 2007

Hospital Name	PFY 2007 Payment
Cambridge Health Alliance	$ 62,264,259
Boston Medical Center (Hospitals and CHCs)	$ 167,123,356
Anna Jaques Hospital	$ 1,398,020
Athol Memorial Hospital	$ 452,034
Baystate Mary Lane Hospital	$ 881,294
Baystate Medical Center	$ 12,323,047
Berkshire/Hillcrest	$ 8,481,772
Beth Israel Deaconess Hospital - Needham	$ 372,248
Beth Israel Deaconess Medical Center	$ 19,917,687
Brigham and Women's Hospital	$ 18,978,949
Brockton Hospital	$ 12,741,713
Cape Cod Hospital	$ 9,817,135
Caritas Carney Hospital	$ 4,764,685
Caritas Good Samaritan Medical Center	$ 4,586,143
Caritas Holy Family Hospital and Medical Center	$ 3,710,510
Caritas Norwood Hospital	$ 2,606,798
Caritas St. Elizabeth's Medical Center	$ 5,674,337
Children's Hospital Boston	$ 10,599,137
Clinton Hospital	$ 644,561
Cooley Dickinson Hospital	$ 2,235,553
Dana-Farber Cancer Institute	$ 2,479,708
Emerson Hospital	$ 954,183
Fairview Hospital	$ 846,221
Falmouth Hospital	$ 2,698,482
Faulkner Hospital	$ 2,034,839
Franklin Medical Center	$ 2,172,513
Hallmark Health System, Inc.	$ 3,053,065
Harrington Memorial Hospital	$ 1,444,764
Health Alliance Hospitals, Inc.	$ 2,727,233
Heywood Hospital	$ 1,464,290
Holyoke Medical Center	$ 3,847,882
Hubbard Regional Hospital	$ 1,037,823
Jordan Hospital	$ 3,698,695
Kindred Hospital Boston	$ 141,788

Hospital Name	PFY 2007 Payment
Kindred Hospital Boston North Shore	$ -
Lahey Clinic	$ 3,656,519
Lawrence General Hospital	$ 8,805,538
Lowell General Hospital	$ 2,487,118
Marlborough Hospital	$ 1,683,392
Martha's Vineyard Hospital	$ 1,087,074
Massachusetts Eye and Ear Infirmary	$ 1,344,018
Massachusetts General Hospital	$ 39,293,395
Mercy Medical Center	$ 5,670,709
Merrimack Valley Hospital	$ 1,544,886
MetroWest Medical Center	$ 5,384,593
Milford Regional Medical Center	$ 2,508,915
Milton Hospital	$ 610,856
Morton Hospital and Medical Center	$ 3,114,583
Mount Auburn Hospital	$ 3,918,676
Nantucket Cottage Hospital	$ 1,161,346
Nashoba Valley Medical Center	$ 943,808
New England Baptist Hospital	$ 185,792
Newton-Wellesley Hospital	$ 2,896,854
Noble Hospital	$ 1,064,189
North Adams Regional Hospital	$ 1,293,592
North Shore Medical Center, Inc.	$ 10,520,719
Northeast Health System	$ 4,878,853
Quincy Medical Center	$ 3,578,291
Saint Anne's Hospital	$ 3,264,892
Saint Vincent Hospital	$ 4,820,638
Saints Memorial Medical Center	$ 2,035,122
South Shore Hospital	$ 4,979,207
Southcoast Hospitals Group	$ 16,536,039
Sturdy Memorial Hospital	$ 2,727,132
Tufts-New England Medical Center	$ 7,089,062
UMass Memorial Medical Center	$ 18,638,695
Winchester Hospital	$ 1,662,311
Wing Memorial Hospital and Medical Centers	$ 2,438,460
TOTAL	**$ 550,000,000**

Note: An additional $70m in payments to the two disproportionate share hospitals with the largest relative volume of free case costs was accounted for when calculating uncompensated care pool payments, but is not reflected in the above payment amounts because the additional $70m is not funded by the uncompensated care pool.